HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF 12

How can gender equity be addressed through health systems?

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How can gender equity be addressed through health systems?

Contents

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At the request of the editorial board, this policy brief intentionally focuses on how health systems could address gender inequities in access to and quality of care, rather than examining broader macro and intersectoral policies that may be aimed at mitigating the health impact of gender-related proximal and distal socioeconomic determinants. As such, the stewardship role that national ministries of health can play is raised as crucial undercurrent to the discussion, but not in relation to developing and financing policies and programmes that can close gender gaps in education and skills as called for in *Closing the gap in a generation: Health equity through action on the social determinants of health*, the final report of the Commission on Social Determinants of Health (published by WHO in 2008).

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Key messages

Policy issues

- Data on mortality, morbidity and use of health services reveal some important differences in health experiences between women and men.
- Health systems can make important contributions to gender equality and gender equity by addressing gender in a variety of ways (see Box 1 on p.3 for what is meant by 'gender equality' and 'gender equity').
- Identifying gender inequalities and addressing gender equity are also central to good stewardship of health systems.

Policy approaches/options

Gender equality and gender equity can be addressed by using various approaches, including legislation, organizational processes and information gathering.

- Regulatory approaches at national level might address patients' rights or create a duty for public-sector organizations to address gender equality. Such a duty would require health ministries to consider the ways in which health systems can reinforce inequality, and to work towards the promotion of gender equality.
- Organizational approaches designed to address gender equity focus on the use (in health systems) of various tools to highlight gender inequalities and pinpoint solutions. For example, gender budgeting is an organizational approach that focuses on government expenditure and makes the gender impact of budgetary decisions explicit.
- Informational approaches focus on the role of data in providing knowledge about gender inequities. For example, gender-sensitive health indicators are intended to identify key differences between women and men in relation to health and in the social determinants of health, in order to support policy change.

All approaches need to be evaluated in terms of their possible benefits, costs and the barriers that might make introducing change difficult. Benefits, for example, include increasing the visibility of gender issues, improvements in population health and in efficiency and value for money in terms of services. Costs can include the increased resources needed for training, monitoring, evaluation and the collection of any new data that might be required. Barriers may include a lack of understanding of the issues and a lack of political will. Factors that might facilitate change could include gender 'champions' and prior

experience (at local or national level) of gender equity reforms in other policy arenas.

Facilitating implementation

All approaches require financial and human resources, political commitment, a long-term approach, transparent decision-making processes, gender-disaggregated data, training and the involvement of stakeholders. A strong stewardship function within the health system can help to take this forward.

However, it is also the case that small changes can help to bring about further change. For example, a requirement for gender-disaggregated reporting of key health data can help generate evidence about the gender gap in health, which can, in turn, support the case for other changes.

Once gender-disaggregated data have become routinely available over time, trends can be observed that help make the case for gender-related budgeting, which can begin with relatively modest goals – assessing the difference between women and men in terms of the use of specific health services, for example – before moving on to strategies that begin to challenge such differences or address gender equity across the system as a whole.

Executive summary

The policy issue and the nature of the problem

Gender differences in health and in how well health systems and health care services meet the needs of women and men are well known: in Europe, there are variations in terms of life expectancy, the risk of mortality and morbidity, health behaviours and in the use of health care services. There is also increasing research evidence demonstrating the importance of a number of different social determinants of health, and these interact with gender inequalities in ways that can magnify the impact on health.

Additionally, there has also been an increasing recognition that health policy may exacerbate gender inequalities when it fails to address the needs of either men or women, and that health systems must address gender equity. This forms part of good stewardship, as well as meeting the needs of the populations served. Gender equity objectives have also been identified in position statements from WHO, the United Nations and the European Union (EU). For the purposes of this policy brief, the 'policy problem' is the way in which health systems might address gender equity in order to reduce the health gap between men and women and to improve efficiency. This document identifies some of the main approaches used to address gender equity in health systems, elaborating on three examples in order to suggest how these methods might be developed in the context of health policies across Europe.

The underlying causes of the gender gap in health which might be addressed by health systems and health care services include differences between women and men in their use of preventive health care, their health behaviours and in their access to health care and treatment – all of which affect health outcomes for women and men. It is difficult to calculate the exact proportion of the gender gap that can be attributed to gender inequality in the planning and delivery of health services. However, the consequences of not addressing gender are likely to include persistent excess mortality among men, underuse, and inefficient use, of health resources, poor user satisfaction and, for some countries, perhaps, a widening gender gap in health.

Approaches to gender equality and gender equity

Health systems in Europe vary in their recognition of gender inequalities and gender inequities. A range of strategies have been used in various countries to address gender equity. These might be categorized as regulatory approaches, organizational approaches and informational approaches. It is important to note that these approaches might need to be combined to address gender equity goals effectively.

- Regulatory approaches include legislation designed to counter discrimination, protect human rights and protect patient rights, and laws that require public-sector authorities to address and counter gender inequalities.
- Organizational approaches include gender mainstreaming, gender-related budgeting, gender impact assessments, health-outcome targets and gender tools that facilitate the assessment of evidence relating to gender differences. These approaches use various tools to identify gender equity issues explicitly in fiscal decision-making, in the drawing up and implementation of policy and in policy outcomes.
- Informational approaches focus on the need for good information, which is central to effective health stewardship. These include the use of gender-sensitive health indicators and gender equity indices such as those used by the World Bank, the World Economic Forum and the EU.

Examples of three approaches

Regulatory approaches

Gender equality duty laws have been tried in relatively few countries. Such laws require public-sector bodies to target gender inequalities actively and to enhance gender equality in everything they do. Benefits include the widespread nature of this approach, which is applied to all public-sector bodies, not just health systems; the resultant 'mainstreaming' of gender issues has benefits for a wider equalities agenda. Costs include the resources needed for dissemination, training, monitoring and enforcement. Barriers include a lack of political will, the time scale involved in passing national legislation, and resource implications.

Organizational approaches

'Gender budgeting' refers to gender-based assessment of budgets, primarily at national level but also at local level, and a restructuring of revenues and expenditures to increase gender equity. It has been used in a number of European countries, although mainly with reference to labour markets, tax and fiscal measures, and has been used less often in health systems. Advantages of gender budgeting include improved economic growth as a result of improvements in women's education or employment, better understanding of the gender impact of different fiscal measures and ease of implementation (as it is a pragmatic approach that can be seen as a relatively easy starting point). Barriers include the need for political commitment and good stewardship and the need for internal expertise (which may be lacking) and good-quality data of sufficient complexity to allow gender assessments to be made.

Informational approaches

Gender-sensitive health indicators are specific national (or international) data sets identified as key indicators of gender inequalities. The selection of appropriate indicators is guided by stakeholder needs, relevance, comprehensibility, clarity, specificity, the appropriate format and time considerations. Indicators allow policy to be designed on the basis of specific and measurable objectives, and also allow policy-makers and others to measure progress toward targets. Indicators are designed to be used alongside other approaches to gender equity. Benefits include the relative ease of introducing gender-sensitive indicators across health systems, their specificity and targeted nature and the association with measurable outcomes. Costs include resource implications if new data have to be collected. Some indicators are criticized for being overly medical in focus, and there is a case for using wider social indicators when planning health systems.

Facilitating implementation

All approaches require a similar set of conditions if they are to be implemented successfully:

- good, high-quality gender-disaggregated data that are routinely available in different formats and at the appropriate level;
- political commitment and ownership of the approach used;
- financial and human resources that are committed over the long-term and not likely to change;
- good, regular and evolving training for all those involved;
- evaluation (including external review) of the interventions and strategies used;
- involvement of key stakeholders at all levels;
- commitment from the relevant stakeholders and decision-makers, and effective stewardship by the government ministry responsible for health.

Policy brief

The policy issue: gender equity in health systems and health care services

There is a considerable volume of research on differences between women and men in terms of their experiences of ill health and how well health services meet their needs. National and international data show that men experience higher mortality and lower life expectancy than women around the world, while women tend to experience more ill health than men, although this varies across the lifespan and in relation to specific conditions *(1)*. In most countries, women also experience a better healthy life expectancy than do men but spend more years living with a disability *(2)*.

Some of this gap between men and women reflects biological differences, that is, differences between women and men in terms of reproductive function, hormones and genetic influences *(1,3)*. Gender is a term that refers to socially constructed differences between women and men, including expectations of roles and responsibilities, as well as differences in patterns of employment and unpaid work *(4)*. Gender is significant in explaining many of the variations between women and men, and health systems can play a key part in reducing health inequalities between them. We know, for example, that there are differences between women and men in the behaviours that contribute to both mortality and morbidity, and health systems that take account of these gender differences in their public health strategies are more likely to be successful *(5,6)*.

Women and men also use health care differently, with the former consulting more often than the latter, particularly in primary care. Men's underuse of some services also needs to be recognized and addressed *(5,7,8)*. A number of studies have also shown that women's and men's experiences of health services – how well the services are able to meet their needs – are shaped by various gender-related influences. Access to services, for example, is affected by opening hours and the availability of appointments, and in some countries by financial constraints. Men in full-time employment are likely to experience difficulties in using health care, but women with caring responsibilities may also find it difficult to access services at certain times *(4,9)*. Services may not be provided in a gender-sensitive way – for example, with provision for single-sex inpatient care or a same-sex physician *(10)*. Questions can also be raised about health knowledge: gender bias in some medical research means that gender differences in the presentation of symptoms, and biological or sex-linked differences affecting correct pharmacological doses, are not fully understood *(1)*.

This policy brief does not rehearse these arguments, but provides an account of the key issues in the delivery of appropriate, accessible and evidence-informed

health care to women and men, and considers how public policies might improve these experiences and health outcomes for both sexes. The benefits, costs and barriers involved in different approaches are also identified. It is clear that health systems can make important contributions to gender equality and gender equity by addressing gender in a variety of ways (see Box 1 for definitions of the terms 'gender equality' and 'gender equity').

Framing the policy issues

With regard to the issue of policy, there are two key elements in the need to improve gender mainstreaming in European health systems. The first is the insufficient attention paid to gender (inequities) in public policy in general and, crucially, in health policy in particular. Second, European health systems generally fail to address the different needs men and women have with respect to health services. Tied to this is the fact that gender sensitivity would appear to be a key aspect of ensuring good stewardship of the health system by the ministries (policy-makers) responsible for health. While they tend to feed into each other, these two elements are separated here in order to identify the specificities of each.

The increasing recognition of the health costs of wider social inequity requires that we consider the ways in which health systems themselves contribute to inequity. In addition, there is growing emphasis in the EU, and by WHO and the World Bank, on the significance of social determinants of health. Gender has been recognized as an important factor in the distribution of such social determinants and this also adds to the need for health policies to identify gender differences in the risks of poor health. Furthermore, the increasing role of market mechanisms in European health systems reinforces the importance of health ministries paying attention to such gender issues as part of their stewardship role *(11,12)*.

There is, therefore, a growing call for the application of WHO's strategy on integrating gender, which urged Member States "to include gender analysis and planning in joint strategic and operational planning, and budget planning as appropriate, including country cooperation strategies" *(13)*. This commitment to tackling gender inequity in government policy follows from a number of earlier movements that focused on the rights of women in lower income or developing countries, particularly in terms of their sexual and reproductive rights. Thus, the United Nations Convention on the Elimination of All Forms of Discrimination against Women (in 1979) and the Beijing Platform for Action introduced by the United Nations Fourth World Conference for Women (in 1995) both called for countries to take appropriate measures (including legislation and the allocation of resources to underpin the strategy) to ensure women's development and advancement, and their equal rights.

Box 1. Gender equity and gender equality

This policy brief focuses on the ways in which health policy might address and promote gender equity. Gender equity and gender equality are terms that are sometimes used differently in different countries and in different contexts, and there is some disagreement as to which term is most appropriate. However, in this policy brief we follow the definition of these terms as used in the Madrid Statement* on gender mainstreaming in health policy in Europe:

Gender equity
"Gender equity means fairness and justice in the distribution of benefits, power, resources and responsibilities between women and men. The concept recognizes that women and men have different needs, power and access to resources, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes."

Gender equality
"Gender equality means the absence of discrimination on the basis of a person's sex in opportunities, allocation of resources or benefits, and access to services."

In terms of health, these definitions are important. Health inequalities between women and men will reflect both biological factors, which are fixed, and gender differences, which are socially constructed and which are open to change. Thus, in terms of health policy the goal is often described as one of gender equity not gender equality. For example, policy should not aim to produce equal levels of mortality or morbidity among men and women, as some of the differences that exist reflect biological influences on health.

However, it is difficult, if not impossible, to know what percentage of the health gap between women and men can be attributed to biology and what to gender. For example, research suggests that women's biology – particularly genetic factors – renders them more susceptible than men to tobacco-related disease, while gender differences in smoking behaviour also play a part. Gender equity in relation to health is not intended to produce equal outcomes for men and women, but instead must address inequalities between women and men in terms of their resources and their opportunities for health, including differences in how well health systems meet their specific needs.

In this policy brief, the term 'gender equity' is used in relation to situations in which women and men have different needs that require recognition in health policy. 'Gender equality' is used in relation to descriptive material concerning health differences and also when describing country-specific actions (where that is the term used in the country concerned).

* as published in *Mainstreaming gender equity in health: the need to move forward* (Madrid Statement), Copenhagen, WHO Regional Office for Europe, 2002.

Member States of the WHO European Region, and EU countries in particular, have also adopted a succession of 'health for all' policies that commit them to the development of equitable health systems and to participation in decision-making. In 1997, the Amsterdam Treaty endorsed gender mainstreaming in the EU, while the Madrid Statement in 2001 expanded this goal with a call for Member States to develop strategies through which gender equity could be achieved. In relation to health, this represented a commitment to gender mainstreaming at all levels of policy, with transparency in decision-making, supported by financial and human resources and the structural capacity to ensure interdepartmental working.

However, while most countries in Europe have committed formally to gender mainstreaming, progress has been slow. Indications of the persistence of gender inequalities come from a number of different sources. For example, despite having some relatively high scores in the Human Development Index produced by the United Nations Development Programme, many European countries do not score well in the Gender Development Index of the United Nations Development Programme *(14)*. Similarly, both the Gender Empowerment Measure (United Nations Development Programme) and the World Economic Forum's report on the global gender gap *(15)* show that European countries have not achieved gender equality (see Table 1). This situation reflects the wide range of countries found in the European region and the significant differences between them in terms of development, economic, cultural and political systems and the health status of men and women.

Although the EU and most Member States signed up to the concept of gender mainstreaming some time ago, the reality of the implementation has often lagged behind for a range of reasons. These include the complexity of the concept, implementation problems, such as difficulties over how to build capacity or where to locate initiatives, and tensions between gender equity objectives and other policies *(16)*. In addition, resources (including gender-disaggregated data and gender indicators that would enable progress to be monitored) are often lacking.

One key area in which gender needs to be addressed is health policy. Gender inequalities in wider society impact on the equitable use of health care, and this is detrimental in relation to both health experience and opportunities, and to the value obtained from health systems. In addition, health systems that are 'gender blind' – that is, where gender differentials in health services are not recognized – may maintain and/or reinforce gender inequalities and gender inequity in wider society, both in their day-to-day operation and in their development of health policies.

Gender and health systems

Data show differences between women and men in terms of mortality, morbidity, use of preventive health care (including uptake of screening), health behaviours and in treatment (including access, use and the types of treatment offered) *(1,2,5,8)*. Women and men interact differently with health systems, partly as a consequence of differences in reproductive health needs, partly because women and men differ in their responsibilities, with more women providing care for others, and partly because men and women vary in their knowledge about health, their recognition of symptoms and their willingness to consult. In addition, the various social determinants of health, including socioeconomic status, paid and unpaid work and culture, vary between men and women. Women and men have different exposures to these risks: in all countries women are more likely than men to be financially insecure, for example, and have a lower social status, while men are more often employed in occupations with specific threats to health – including for example construction work where there are increased risks of accidental injury *(8)*. However, there are also important differences among women, and among men, reflecting socioeconomic status for example, which further affect their risk of poor health and problems concerning access to services and experience of health systems.

Thus, there are no simple answers to the questions of where the problem lies and how it might be addressed. Where studies have evaluated interventions that address gender inequities, there is evidence of improvements in service delivery and user satisfaction *(17)*. Overall, the lack of a gendered approach in most health systems suggests that a new focus on gender equity in health policy across different levels (including governance, financial and delivery arrangements, programme coverage and reimbursement) might offer substantial opportunities for progress and improvement.

At the same time, it is important to consider ways in which the health sector could work in partnership with other sectors to promote social and economic development, particularly where this approach would allow a wide range of social determinants of health to be addressed. The WHO Regional Office for Europe's 'Investment for Health' initiative, for example, supports cross-governmental action as well as practical applications, such as action learning sessions for senior policy-makers from a range of government departments involved in economic regeneration and poverty reduction, alongside those involved in health.

The size of the problem

Data demonstrating the health gap between women and men in healthy life expectancy, for example, or in years of life lost, reveal a complex picture in

which men in Europe suffer a shorter life expectancy while women spend longer living with a disability and report more ill health and long-term conditions *(18)*.

It is difficult to assess what proportion of these health differences between women and men reflects failures in health systems as opposed to differences in human and social resources, for example. Empirical data show important differences between women and men in terms of access to, and use of, services, and in terms of the adequacy and appropriateness of care – men's lower usage of primary care and preventive services, for example *(19)*. There is also evidence that health behaviours carry significant weight in shaping vulnerability to various conditions *(20)* and that gender differences in such behaviours are important in helping to explain the gender gap in health. If we consider the roles and responsibilities of health systems to include not only treatment but also health promotion and public health, then data on the extent of the gap between women and men can be presumed to indicate that there is a significant public health cost from not addressing gender adequately in health systems.

Countries in transition, including, for example, Albania, Latvia, Lithuania and Ukraine, are of specific concern. These countries vary in terms of where they are on both the Human Development Index and the Gender Development Index and also how they are positioned in the Gender Gap List (see Table 1). Many countries in transition have experienced falling life expectancies in recent years, and, because male life expectancies have decreased more than female life expectancies, the gender gap for mortality has widened. In the Russian Federation, for example, the gender gap in terms of life expectancy has widened to 14 years and male morbidity has also increased *(21)*. These countries also illustrate the importance of targeting gender equity in health systems for both men and women.

From a policy perspective, health ministries often lack mechanisms for addressing gender differences in health. Health policies often do not identify gender differences in the impact of interventions or strategies, while the systems of governance that oversee such policies also tend not to identify gender differences in an explicit way. In addition, the health information used to support stewardship may be presented in a gender-neutral way – for example, as aggregated, rather than disaggregated, data. A lack of transparency in the governance of health systems means that it is rarely possible to assess the extent to which gender has been taken into account in the development, administration and delivery of health services. Furthermore, it is not easy to identify the implications, in terms of cost, efficiency and health outcomes, of this failure to address gender in health systems. Thus, when thinking how to 'gender' health policy, it is important to ensure that

transparency is increased and that the impact of interventions on both men and women is evaluated.

The consequences of maintaining the status quo

Health systems that fail to address any form of inequity might produce a range of consequences, including premature mortality and poorer health among those experiencing inequalities, and increased burdens on health care systems. Thus, there are a number of consequences of gender inequity. The first, and most important, is that the existing gap between women and men in terms of mortality and morbidity may persist. While part of this gap reflects differences that are biological in origin – women's protection from some autoimmune diseases, for example – much of the gap reflects differences based on gender, including differences in health behaviours such as smoking and tobacco use. There are significant costs for health systems and wider society as a result of this gap, especially the social and economic costs of excess premature male mortality and excess morbidity. It is also possible – notably in countries experiencing an economic downturn or major change – that without action the gap might widen, particularly where economic change is associated with changes in the financing of health care as well as unemployment.

Other costs of failing to address gender differences include reduced user satisfaction with services, which may affect both men and women depending on which services are highlighted. This can also lead to less-efficient use of services, which in turn affects health outcomes. In addition, failure to tackle gender inequities can lead to poorer morale among health professionals and untapped resources among both men and women working in the health sector. For example, gender inequalities affecting women at the level of the workforce, including poorer employment conditions and discrimination with regard to opportunities for promotion, can result in higher attrition among female staff and the loss of trained and valuable employees.

It is also important to recognize that there may be opportunity costs arising from focusing on one form of inequity rather than another. The addressing of gender equity may result in the diversion of resources from policies that could tackle other forms of inequity. However, gender inequalities are likely to be significant burdens for those who also experience other forms of inequality or disadvantage: many of the worst problems arise when individuals experience multiple forms of inequity (as a result of the intersections of socioeconomic status, ethnicity and gender, for example). For policy-makers, there are also cross-cutting benefits from addressing gender equity in that crucial lessons are learned in relation to the implementation of equity-driven policy, for example, and such moves can also lead to better understanding of equity issues both within and beyond the policy arena.

Approaches for gender equity

Health systems across Europe vary in the extent to which they have recognized gender equity as an issue, and in the ways in which they have framed the question and implemented change. It is not possible in a short brief of this kind to detail the approaches used in each country of the European Region. Instead, a short overview of the different ways in which gender has been addressed, both in Europe and in other parts of the world, is provided.

Sections below refer to various studies and expert commentaries in making the case for various approaches. There are few syntheses based on research evidence in this field, and it should also be noted that some approaches are relatively new and so it may be some time before evaluations of their impact are available. The studies referred to in this report are selected to provide illustrations of the way in which an approach might be used and the potential benefits and costs, from European sites wherever possible.

It is also important to note that these strategies overlap and that countries have pursued different combinations of approaches. For example, the decision to adopt gender budgets leads to a need for high-quality, regular and appropriate gender-disaggregated data, while gendered targets or benchmarks may also demand the development of specific outcome measures or indicators.

Given the complexity of the various approaches that have been used in gender mainstreaming and in addressing gender equality and gender equity, it is helpful to divide the different strategies according to their primary focus. This permits the exploration of strategies focused on regulatory and legislative arrangements, those focused on organizational options and those that focus on information.

Regulatory arrangements and legislation

Gender equality legislation has been enacted in a number of countries in Europe following international initiatives such as the United Nations Convention on the Elimination of All Forms of Discrimination against Women, as well as directives from the EU. However, the value of this legislation varies both in terms of content or cover and also how strictly the laws are enforced.

Many countries have human rights and anti-discrimination laws, but these are limited in that they give individuals protection from discrimination rather than actively requiring organizations to promote equality. Gender equality legislation has also tended to focus on women's and men's participation in the public sphere – political representation, membership of legislative and other bodies, education and employment rights, including pay – rather than equity in terms of access to, and appropriateness of, health care services and health systems.

A smaller number of countries in Europe have further developed anti-discrimination and equality legislation by requiring public bodies, including those in the health sector, to counter discrimination actively and to promote gender equality. For example, the 2006 Equality Act passed in the United Kingdom and the Norwegian Gender Equality Act of 2002 both included a duty for all public authorities to promote gender equality. These legislative changes led to the use of a variety of measures, including gender budgeting and gender impact assessments (see below), at regional, national and local levels across a range of public-sector activities.

In addition, in health systems, legislation concerning the rights of patients can be used to promote gender equality. Since the 'Declaration on the Promotion of Patients' Rights in Europe' in 1994 (WHO Regional Office for Europe), a number of countries in Europe (14 by 2002) have introduced patients' charters or laws on patients' rights. These approaches offer patients an opportunity to challenge health systems on legal grounds, that is, in terms of the denial of their rights as patients because of gender-based discrimination. Such approaches have their limits, however, including a lack of knowledge among patients, a reluctance to make such challenges and a lack of knowledge among health professionals as well as policy-makers *(11)*.

Organizational approaches

There are a number of organizational options (outlined below) that can be developed to address gender issues, including gender mainstreaming, gender budgeting, gender impact assessment, targets for health outcomes and gender tools.

Gender mainstreaming

Gender mainstreaming aims to address gender explicitly in policy, through a systems approach that integrates gender analysis and gender impact assessment at every level of policy. Such approaches have been important in development policy and in international organizations such as WHO, the United Nations and the EU, but, worldwide, they have less often been introduced at country level.

Gender budgeting

Gender budgeting refers to gender-based analysis of various stages of the budgetary process and is often set in the context of human rights and legislative changes. Gender budgeting alone is not sufficient to bring gender equity, but should be part of a wider strategy in terms of gender mainstreaming, including, for example, gender impact assessment *(22)*.

Gender impact assessment

Gender impact assessment was pioneered in the Netherlands and has been used in a number of other European countries. It has been defined as "the (re)organisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy-making" *(23)*. In the Netherlands, 22 gender impact assessments were carried out between 1995 and 2006, including one conducted by the Ministry of Health, Welfare and Sports *(23)*. The process was seen as being underpinned by three elements: structures – referring to the identification of the most significant institutions and organizations in terms of gender inequalities; processes – an understanding of the mechanisms by which gender relations are constituted and reproduced; and criteria – meaning the ways in which interventions and outcomes were to be evaluated.

Gender-specific targets

Gender-specific targets are another option for organizational approaches. They are promoted as part of the 'European Health for All' strategy of the WHO Regional Office for Europe. The targets are focused on outcomes rather than inputs and create an environment in which health systems are required to deliver specific results. Targets or benchmarks can be set at international level, as exemplified by the Millennium Development Goals. To be successful, targets need to be 'owned', measurable, involve stakeholders and include management incentives *(24,25)*. Health targets are used increasingly within countries, at various levels of health policy *(24)*, and set a commitment for specific outcomes in a specific time frame. They may focus on issues relating to perceived quality of care, such as patient satisfaction, or health outcomes, including reductions in disease-specific mortality rates, for example. Targets can be set at national, regional or local level, or all three, as they are devolved through health systems. In England, for example, national targets for mortality reduction are set as part of government expenditure plans; there are specific goals for individual ministries (including that for health) and for the dates by which these goals should be achieved. These are incorporated into Public Service Agreements, and departmental funding is linked, in part, to these targets.*

Health-system targets have, in the main, not been gender-specific. However, it is possible to include 'gender dimensions' based on evidence of health differences between women and men. For example, targets in relation to use of

* In 2007, Public Service Agreement 18, for example, outlined a national target of an increase in average life expectancy at birth in England to 78.6 for men and 82.5 for women by 2010.

health care might have specific goals for men and women to reflect current patterns. Screening programmes (such as those for bowel cancer that are currently being either piloted or introduced in a number of European countries) might aim for gender-specific increases in annual uptake, in response to the currently low uptake among men, rather than adopting a global target.

It should be noted that there is little rigorous evidence demonstrating the success of health targets or indicating long-term gains *(24)*. It is also possible that targets might distort outcomes where they encourage the switching of resources to one objective at the expense of others that have not been identified as targets. Thus, the use of health targets in a gender-specific way needs to be accompanied by robust evaluation of the consequences for men and women, and also analysis of any emerging unintended consequences where such targeting has encouraged a shift in focus or resources.

Gender tools of analysis

'Gender tools of analysis' is a term that describes an organizational approach. Such tools help to identify gender inequalities and potential policy interventions *(25)*. Gender tools are part of an overall strategy rather than a stand-alone approach for gender equity. For example, the WHO Regional Office for Europe, in its gender-tool strategy for child and adolescent health *(26)*, includes a 'health priority table' that uses separate columns to identify, for a number of key health issues, the relevant priorities, gender pathways affecting the health issue, the information that is needed, health-system actions and intersectoral actions that go beyond the remit of health policy.

Gender tools can be used at various levels of policy-making, from national strategies (such as responses to cardiovascular health) to local strategies (such as attempts to increase the uptake of specific services). Gender tools have already been developed to analyse the relationships between gender and the following factors: social determinants of health; health behaviours; quality of care; health promotion; the impact of health financing; health policy; and institutional management *(25)*. If gender tools are to be of value, gender-disaggregated data, training, institutional acceptance and financial and human resources are required.

Informational approaches

Good information is an essential part of health stewardship and the promotion of health equity, and the approaches outlined above all call for gender-disaggregated information. The third approach for gender equity used to varying degrees in European countries relates to the provision and use of such information. There is a need for gender-disaggregated data in all health systems. These data need to be routinely available across the health system,

they need to be comprehensive and readily accessible. Unfortunately, these requirements are still not being met in a number of European countries. In addition, there is a need for what are sometimes described as 'gender-sensitive health indicators' and for public reporting of the gender gap. Indices of gender equality and gender equity are also valuable: they are compiled from data from a range of sources, including censuses, sample surveys and nationally collected statistics, in order to 'give shape' to gender-disaggregated data *(27)*.

Analyses of indices of the gender gap, such as the World Economic Forum's publication *The Global Gender Gap Report 2007 (15)*, provide insights into the gap between women and men in relation to specific indicators representative of gender (in)equality. On the basis of indicators, including economic participation, representation in the public sphere, and education, countries are ranked by their gender gap. In 2007, for example, Sweden came top among European countries, having an equality score of 0.815, whereas Turkey came last, with a score of 0.577 *(15)*. The World Economic Forum's calculation of the gender gap includes two indicators relating to male/female health differences: the sex ratio at birth and the female/male ratio in healthy life expectancy (based on the estimated number of years lived in good health, taking into account the impact of disease, violence, malnutrition and other factors).

Thirty-five countries worldwide share equal first place for the narrowest gap between men and women on this composite health indicator. These countries are diverse in terms of their overall health achievement: Angola and Yemen score well in terms of gender equality in health (despite their relatively low healthy life expectancies) alongside Austria and France, where the healthy life expectancies are higher. This suggests that while an approach that combines a number of indicators is a valuable tool at global level, particularly in the political realm, it may be more helpful to focus on detailed and health-specific indicators within and between European countries.

Gender-sensitive indicators help to provide solid evidence for the development of a gender-sensitive policy and also supply evidence regarding changes in health outcomes for both men and women. They can be used in different contexts and in countries with different health systems, thus permitting cross-national comparisons of the gender gap in health.

Health surveillance data are currently widely used in a number of European countries to support health planning, the implementation of policy and the evaluation of the success of different services and strategies. For example, the European Community Health Indicators project developed four categories of indicators: three referred to social and other determinants of health, while the fourth referred to health outcomes. Assessment, and consideration, of the role of gender-sensitive indicators in health surveillance data already in use further

strengthens the value of this approach. In many cases, new indicators will not be necessary, but existing indicators need to be evaluated. For example, are they gender-disaggregated, how sensitive are they for gender purposes and are they capable of reflecting gender differences in changes to outcomes following interventions?

Gender-sensitive health indicators and gender-disaggregated data may be particularly important in health-sector reform, as changes can have unintended consequences for gender equity which need to be explicitly addressed *(12)*. For example, the introduction of, or changes to, user fees can impact differently on women and men because of women's greater financial insecurity *(12,28)*, while changes designed to reduce lengths of hospital stay are also likely to adversely affect women more than men because of gender differences concerning responsibilities for unpaid care in the home *(4,29)*.

Policy approaches: three examples

For each approach, one example has been selected to illustrate the key issues in gender equity in health systems. These examples show how the approaches have been applied, demonstrate the key principles and indicate their value in the context of health systems.

Regulatory approach: gender equality laws

Regulatory approaches to gender equality take a number of different forms and are often iterative in that legislation is generally added to and consolidated over a number of years. This section focuses on those approaches in which legislation requires public-sector and private-sector organizations (including those involved in the delivery of health and social care) to act in such a way as to promote gender equality. The rationale offered for legislation is primarily that the proactive requirement placed on the public sector to advance gender equality is more effective at introducing change in relation to more complex forms of inequality *(12)*. As yet, however, there has been relatively little research on the outcomes of such legislation. One analysis of the factors influencing the introduction of legal approaches for gender equality suggests that various political pressures are as important in the development of equality legislation as evidence of effects *(30)*.

'Public-sector duty' legislation, which requires organizations to promote gender equality actively, as opposed to laws that protect individuals from discrimination, is relatively rare. Such legislation has recently been passed in Norway and the United Kingdom.

In Norway, the Gender Equality Act 2002 (section 1a) stated that "public authorities shall make active, targeted and systematic efforts to promote

gender equality in all sectors of society". In the United Kingdom, the Equality Act 2006 placed a general statutory duty on public authorities to "promote equality of opportunity between men and women". Public authorities are required to draw up and publish gender equality schemes that describe the steps they are taking to meet the requirements of the Act. In doing this, public bodies are required to consult with various stakeholders and interest groups, and to publish the results of their schemes on a regular basis. Known as a public-sector duty on equality, the legislation calls for organizations to demonstrate how they pursue gender equality when carrying out their public functions. This duty operates alongside a similar one in relation to disability, ethnicity and sexual orientation, and also includes a requirement in relation to transgender persons.

The Department of Health in England has established an Equality and Human Rights Group, which works on all aspects of equality. The Group offers an overall perspective: it aims to provide strategic leadership on equality issues across the Department's activities, through support and advice on policy, identification and articulation of the 'business case', the provision of examples of good practice, the creation of innovative programmes for change and the development of partnerships with stakeholders, regulators, patient and staff groups and others.

The Department of Health has also drawn up an action plan for 2006–2009 ('Single Equality Scheme' *(31)*) detailing targets regarding equality (including gender equality in health systems), the measures to be used to assess outcomes, the action needed and those responsible for carrying it out, together with a time scale. The targets included broader aims, such as improved outcomes in health services for men and women, and more specific ones such as increasing the rates of breast cancer screening among women. The plan highlights the essential role of governance in relation to achieving the equality-duty responsibilities.

The gender equality duty filters down throughout the health system, so those involved in delivering health care at the local level are also required to draw up and publish a gender equality scheme and evaluate their performance. This involves asking questions about whether men and women have different issues in relation to health care, different requirements and whether their needs are likely to be met appropriately by existing services. Health organizations also have to conduct gender impact assessments of new policies, strategies and interventions.

One of the main advantages of this kind of regulatory approach is that it is proactive rather than reactive, in that public-sector bodies are required to address gender. In health systems, where it may be less easy for individuals to prove discrimination than in employment, for example, this is important. This

approach also has the effect of mainstreaming gender: the subject has to be considered in everything that an organization does. It places gender equality in a central position in policy-making and right through to the delivery of care. It is also possible to make gender part of a wider equalities agenda; this, in turn, enables those implementing different strategies to learn from each other and from examples of good practice across the spectrum.

When such a duty is introduced, there is a need for good evaluation and dissemination over a long period prior to the legislation becoming live, and afterwards. Costs are likely to be high, partly because of the resources needed for dissemination, but also because of the need for training, support and enforcement. There can be confusion within organizations (particularly those in the voluntary sector) as to whether they are included and also how such a duty might impact on their work in the initial phase, for example, causing anxiety regarding the legality of providing services that are only for women or only for men. There are also resource implications arising from the need for regular evaluation (preferably by outside organizations) of gender equality schemes and also from the need for monitoring, and enforcement, of the law. One of the main barriers to pursuing this approach is that it is based on national legislation and is therefore difficult to introduce, requires political will and 'champions', and takes time to become effective.

Organizational approach: gender budgeting

Public goods are consumed by men and women to different degrees and "women and men benefit differently from social transfers" *(16)*. Gender budgeting is one way of recognizing, and attempting to redress, these differences. The term gender budgeting, or gender-responsive budgeting, includes a number of different approaches that focus on government expenditure. The European Council defines gender budgeting in the following terms: "Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality" *(32)*.

An important aspect of the gender budgeting approach to gender mainstreaming is that it allows an examination of the impact of budgets on a number of demographic groups and, as such, can address disadvantage associated with ethnicity, class, geographical factors, age or disability, for example. Although the focus in this brief will be on budgeting that is specifically gender-responsive, it may be helpful to bear these other issues in mind.

Gender budgeting does not refer to resources allocated specifically for either sex, such as budgets for women's programmes, but calls for a gender analysis of the impact of fiscal and monetary measures on both men and women *(33)*.

A country's national annual budget is a statement of government priorities over the next year, including financial allocations in relation to competing priorities and also the manner in which revenue is to be raised. With gender budgeting, gender differences in relation to needs and experiences in the context of public-sector expenditure are explicitly considered in this process. Thus, gender budgeting aims to determine the following: the specific needs of men and women; whether current measures and policies meet the needs of men and women; and how any failure to meet the needs of men and women should be addressed. In addition, an objective of gender budgeting is to increase government accountability for gender-based differences in terms of the impact of public-sector expenditure and revenue measures *(27)*.

Gender budgeting was first applied in the form of a 'women's budget' in Australia in 1984 and has since been pursued as a gender equality strategy in a number of countries – led, to some extent, in Europe by EU initiatives *(34)*. The approaches taken have varied, both in terms of the gender budgeting techniques used and also the level (national, regional or local) at which such budgeting measures have been taken up. The stated goals of gender budgeting have also varied but, in general, objectives include improved gender-disaggregated data, explicit recognition of the gender impact of policies, and movement towards gender equality.

Between 2004 and 2006, the Nordic countries ran a gender equality project consisting of a number of pilot programmes conducted at country level, the aim of which was to evaluate ways in which governmental processes might be used to advance gender equality at national level. As part of this project, several countries pursued a gender-based analysis of budgetary processes. From 2002 onwards, the Norwegian Government introduced measures to address gender equality in their annual fiscal budgets. In Finland, the focus was on the budget held by the Ministry of Health and Social Affairs. Meanwhile, in Scotland, gender budgeting has incorporated a range of activities, including, for example, a gender audit commissioned by the Scottish Government.

In most countries, however, gender budgeting has primarily been used in relation to government policies on the following: fiscal measures concerning the labour market, tax and pensions; social security or income maintenance systems; and child care. Gender budgeting has less often been explicitly applied to health policy, although some of the requirements of the approach – gender-disaggregated data and gender indicators – have been extended to questions of health policy.

There is no single model for gender budgeting. A variety of approaches have been adopted, reflecting different contexts, political systems, local versus regional versus national policy machinery, and also stages of economic development. Key principles for the implementation of gender budgeting in

most settings include the need for transparent procedures and decision-making, participation by the different stakeholders, sustainability and a long-term perspective *(22)*. Gender budgeting can be focused on specific policy issues, the budgetary process as a whole, or both; the key is that spending choices – and their gender impact – should be explicit.

A number of specific instruments have been associated with gender budgeting, including gender-sensitive policy processes, gender-disaggregated analysis of benefits and beneficiaries, gender-disaggregated data, gender auditing of expenditure and revenue to explore differences between women and men, gender impact assessment and gender equality targets *(34,35)*.

In reality, various approaches have been pursued. In Nordic countries, gender budgeting means an analysis of the fiscal budget in order that expenditures can contribute to reductions in gender inequality, and all ministries have been required to carry out gender equality assessments in their budgetary areas. This has been pursued through gender equality analysis of policies, scrutiny of existing objectives and indicators, the development of new gender-specific objectives and indicators, and the identification and allocation of financial needs. The final stage is an evaluation of outcomes and the impact on different groups of women and men.

In the United Kingdom, the independent Women's Budget Group advises the Government and aims to promote gender equality through the use of gender analysis. This has included working with the Treasury in developing gender-based budgets. In Scotland, the recently devolved government has adopted a gender budgeting approach that is evaluated by a nongovernmental organization – the Scottish Women's Budget Group. The process follows three stages: setting the priorities and expenditure strategy; preparing detailed expenditure proposals in a draft budget; and enacting the budget bill. In their evaluation, the Scottish Women's Budget Group has been critical of the lack of gender-specific targets and has highlighted a perceived failure to prioritize gender equality; this highlights the importance of capacity building within government departments, as well as transparency and the involvement of stakeholders, if gender budgeting is to work.

There are a number of prerequisites for gender budgeting to be effective, including political commitment, adequate financial and human resources, inter-sectoral collaboration, gender-disaggregated data and transparent processes *(33)*. The responsibility for action needs to be clearly identified and appropriately placed. In Sweden, for example, where gender mainstreaming and gender budgets were central to the 'National Action Plan for Gender Equality 2004–2009', the focus was at national level and the decision-making was done in government offices. It is also possible, however, to use gender budgeting approaches at local level – for example, in the planning of local

health services. Plans for a new hospital can be evaluated in terms of the different services to be offered to women and men and the likely uptake, reflecting not only population needs but also barriers to the use of existing services (and how new services might overcome them). Such an analysis would be a cross-service one, in the sense that the availability of public transport, the local employment opportunities and the educational and child-care facilities (and the availability of care for other dependants) might also be considered.

What evidence is there of the impact of gender budgeting on health policy and gender inequalities? Most of the literature about this approach, and most experiences of it, have related to women, not men and women. Often, gender budgeting approaches focus on economic differences between women and men, particularly in relation to income, employment and earnings. Most effects, therefore, have been seen around employment and associated benefits, social security or state income-maintenance schemes, pensions, tax credits and so on. However, health systems consume a significant proportion of total government expenditure and if gender budgeting helps target resources more effectively this offers significant potential for value for money. Although there are few examples of the way in which gender budgeting might be applied to health policy, it is clear that the approach would help to highlight gender inequalities in health-service use, treatment and outcomes.

Examples of gender budgeting in health can be found at different levels. In Sweden, a 'micro-level' approach was adopted to consider gender differences in the use of one specific hospital service, and the reasons behind a gender gap in the uptake and completion of treatment *(36)*. In Norway, gender budgeting led to different approaches at different levels of policy: these included a statistical supplement to the annual budget statement that contained data on health-service usage by women and men and an analysis of the usage of specific services (such as a public health clinic for young people) *(37,38)*.

The economic rationale for gender budgeting in health systems highlights external factors, although there are also social arguments for the introduction of the approach. Such arguments include those highlighting the ways in which apparently gender-neutral policies in fact conceal important gender differences that are revealed by gender budgeting.

The benefits of gender budgeting are generally related to improvements in the budgetary system as a whole: "Gender budgeting is just good budgeting" *(27)*. Research shows that the approach is associated with improved economic growth (see for example, a guide to gender budgeting, published for policy-makers, government and development agencies, as part of the work of the inter-agency programme of the Commonwealth Secretariat, IDRC and UNIFEM *(39)*). Furthermore, resources may be targeted more effectively as a result of gender budgeting, leading to efficiency gains and improved service delivery for

both men and women *(22)*. For others, gender budgeting is seen more pragmatically as a relatively easy starting place – that is, it represents a mechanism for gender analysis of an existing budget, highlighting gaps and problems and providing a defendable and relatively easily understood starting point for the implementation of gender equality measures *(16)*.

With gender budgeting, there is a need for good-quality, regularly produced gender-disaggregated data at the right level of detail. Those involved in different stages of the process are likely to require training (linked to specific roles and responsibilities). The process also needs to be evaluated internally and by outside researchers. Problems may arise if gender budgeting is imposed rather than being introduced in such a way that policy-makers at all levels can engage with. It is also important to have clarity with regard to the procedures and their implications. The gender-based analyses needed to support gender budgeting should be drawn up by in-house experts, not outsiders, if they are to be meaningful and contextualized; it is an approach that should be integrated with normal work rather than being separate.

If this approach is to be of value, it also requires a high level of political commitment across the different departments responsible for gender analysis, gender impact assessment and the introduction of gender budgeting measures. Is should be adopted as a long-term, sustainable process. Good stewardship would involve transparency of both the gender budgeting process and the decisions made as a result of it.

Informational approach: gender-sensitive health indicators

Focusing on an informational approach, gender-disaggregated data are essential for addressing gender equity, and in some parts of Europe the production of routinely disaggregated data would be a significant step forward. The example examined here in more detail is the use of gender-sensitive health indicators. Good stewardship in terms of health policy needs to be based on solid evidence-based analysis of differences between people, including those differences based on gender. Gender-sensitive health indicators are important tools in this context, particularly when they are further differentiated by ethnicity and socioeconomic factors. While health indicators are in widespread use, it is only relatively recently that the need for gender-sensitive indicators has been identified.

In 2003, the WHO Consultative Meeting on gender-sensitive core health indicators identified such indicators as having the primary aim of enabling countries to detect potential sources of gender inequity in relation to health status, the determinants of health and also the performance of health systems. In addition, indicators are seen as a means through which mechanisms for addressing such inequities might be identified and developed. WHO agreed a

three-tier set of 35 health indicators incorporating 11 indicators on health status (such as maternal mortality ratio, and male and female rates in self-reported depression), 13 on determinants of health (including, for example, decision-making on own income and health behaviours) and 11 on health-systems performance (including indicators based on usage of various services, waiting times and expenditures), although it was observed at the time that this list is relatively long and may need to be reduced in the future (see Table 2).

Not all of these indicators are of equal value in all European countries, and it is important to link the indicators with each country's circumstances. While lower-income countries with poor infrastructure, high mortality and a heavy burden of ill health may benefit from using the WHO list, higher-income European countries may find some of the core indicators (access to adequate sanitation or potable water, for example) to be too blunt as measures of inequality. The selection of specific indicators at country level therefore needs to be guided by clear principles, which should be determined in advance but also regularly (re-)evaluated *(40)*. To maximize the value of gender-sensitive indicators, it is important to consider a number of aspects of the indicators and their development.

Participation and stakeholder involvement

There is some evidence that consumer involvement in the planning of health care and in the development of policy helps to produce better care, greater user satisfaction and improved health *(41)*. Similarly, the involvement of various stakeholders, including policy-makers, end users, health professionals, health researchers and representatives of service users, in determining the types of indicators used offers opportunities for the development of more appropriate indicators and also increases the likelihood that indicators will have wider acceptance *(40)*. There is also a need to ensure that the stakeholders represented include those with gender issues in mind.

Relevance

Different users will have different needs, in terms of both specific information and also the format used. For example, not all users will need the same level of detail. Some might require data that are further disaggregated by other forms of difference. National-level indicators may need to be drawn up to enable international comparisons; it is important to strengthen policy-makers' ability to compare their own policies with those of other countries. Local-level policy-makers are likely to need more detailed indicators that are broken down by socioeconomic, ethnic and geographical groups, matching the population they serve. It is important to consider the different requirements that apply in relation to gender-disaggregated information at different levels.

Comprehensibility

Gender-sensitive indicators have to be easily understood by all users, and how they are understood might vary in terms of the different levels of the organizational structure where they are to be used *(40)*.

Clarity of definition

Indicators have to be clearly defined in terms of what they are, what they represent, what they cover and what they do not cover, so that their interpretation is consistent and not open to variation *(40)*.

Number

In health systems, a small number of indicators is preferable to a long list. This helps to avoid information overload and also the difficulties caused by composite indicators (which might obscure important differences in component data). In addition, the indicators are more likely to be compiled and produced regularly and are more likely to be used. It is important, in health systems, to identify those indicators which provide the most appropriate information in terms of gender equality or gender equity, as they will vary for different users and in different parts of the health system *(40)*.

Specificity

Gender-sensitive indicators should serve to inform policy-makers about the value and appropriateness of interventions. They need to have the right degree of complexity at national, regional or local level (according to the location of the responsibility for planning and delivery) *(42)*.

Format

The format in which indicators are provided is important. It could be either in electronic form or on paper, but what is most significant (for some users) is how easily the data can be manipulated to meet specific and variable requirements as and when they are needed.

Timeliness

Gender indicators need to be regularly collected and updated. In addition, the content should be evaluated and revised as necessary. Feedback needs to be institutionalized: arrangements should be made for different types of users, for example by including electronic feedback systems, consultations and monitoring of the uses made of data *(42)*.

Overall, there is relatively little research comparing different indicators. Some work has been done on the health indicators developed by the EU in its 'Health Monitoring Programme' and in the 'European Community Health Indicators' project *(43,44)*, but these indicators were not designed to be used in relation to

gender equity. One field-test of the WHO core set of gender-sensitive health indicators, carried out in Canada, suggested that while national and regional data did provide evidence of a gender gap in health, the data did not offer sufficient detail to identify disparities among women and among men, including differences by ethnic group, age, socioeconomic status and region *(13)*. The field-test also suggested that more indicators on morbidity might be needed in countries such as Canada, where some health events are relatively rare. For example, they suggested expanding maternal mortality to include measures of maternal morbidity, such as hospital readmission following birth. Although data on suicide represent a useful gender-sensitive indicator, the authors of the field-test suggested that self-inflicted injury shows important gender differences and should be added; similarly, the gender gap in both accidental and non-accidental injury indicates that it would be useful to include data on such injuries.

These authors also recommended the addition of data on health utilization in order to complement survey and self-report information, which can underestimate some health behaviours, particularly substance abuse, alcohol consumption and smoking. A mixture of self-reporting and health-utilization measures allows clearer analysis of the gap between need and treatment, which may in itself be gendered. For example, depression may be under-diagnosed and under-treated for men and women in different age groups. A further recommendation was that users of health indicators need to explore interactions between the indicators and the potential role, in terms of health status, of different combinations of these measures.

Gender-sensitive indicators need to be seen as part of an overall gendered approach to health systems, as outlined sequentially below (adapted from *(45)*):

- goals: broad statements of desired directions
- objectives: specific and measurable statements
- indicators: detailed means of measuring progress towards goals
- targets: statements of progress to be made in measurable outcomes, together with dates
- strategies: coordinated set of interventions designed to achieve goals.

Indicators that are selected will be more effective, and more likely to be 'owned' across different departments, if they are associated with gender-specific health policies and measures of outcome and linked across several tiers of policy *(7,46)*. Cwikel suggests using a four-tier approach; lung cancer is used as an example *(46)*. The tiers could operate as follows: in the top tier, the target might be a reduction in lung cancer mortality; in Tier 2, the determinant – smoking behaviour – could be targeted; in Tier 3, public-health policy might be

to introduce bans on smoking in public places; and the fourth tier – community approaches – might include advertising bans. Finally, it is important to note that all indicators describe an event or outcome rather than providing explanations of how or why these have occurred; gender-sensitive analysis of the indicators is crucial to their value.

Gender-sensitive health indicators encourage a focus on specific and measurable targets in relation to gender equality, they can be used alongside other approaches, and the list of necessary indicators can be drawn up in relation to a country's needs, circumstances and population. Indicators can also be relatively easy to introduce at different levels of health systems.

There are costs involved for governments, where additional data have to be collected in order to construct gender-sensitive health indicators. However, much of the data required for commonly used gender-sensitive indicators is found in statistics that have already been collated, in which case the additional cost of gender-disaggregated data is smaller. Other costs might include the organization of consultation (to ensure that the views of the different stakeholders are represented) and the evaluation of the indicators on a regular basis.

Health indicators can be criticized for focusing on biomedical measures of health status – such as mortality data, for example, or measures of specific conditions and symptoms *(47)*. Some commentators have argued for the inclusion of indicators reflecting the social determinants of health, including structural inequalities such as those relating to employment, unpaid labour and housing *(7,48)*. Evidence concerning socioeconomic differences between women and men suggests that, for the purposes of gender equity, it is important to develop health indicators that go beyond biomedical measurements of health.

Facilitating implementation

The approaches reviewed above identify similar necessities if gender equity is to be addressed and change is to be brought about.

Firstly, all approaches will require gender-disaggregated information that is of high quality, regularly produced, available in different formats and set at an appropriate level. Although European governments produce data routinely, the information is not always disaggregated by gender, so, in some instances, further data will also be required. However, without a strong commitment to the production and dissemination of such data at both national and local level, these approaches will not achieve their potential *(49)*.

Secondly, all approaches need to be owned across the organization and have long-term political commitment. Although it is only possible to introduce gender equality legislation, gender budgets or gender-sensitive health

indicators if these ideas are shared by a number of players, the success of their introduction also requires the existence of strong, broadly based commitment to such measures. This is particularly important where there is resistance to the idea or where gender equity is seen as being achieved at the cost of either service improvements or other inequities *(49,50)*. In this regard, effective stewardship of the health system by the ministry responsible for health can thus be seen as one of the keys to promoting gender equity in health systems. Issues in relation to equity – including gender – are central to stewardship, because equity needs to be addressed through a comprehensive approach in which action is taken at a number of levels and across a number of fronts. All of the activities inherent in the stewardship role performed by health ministries – the overview of health care financing (including organizational and regulatory matters) and the generation of resources for health systems (including staffing, information, infrastructure, purchasing and the provision of services) – are areas in which gender equity could be addressed. For example, health systems represent important employers and purchasers and are therefore able to promote gender equity by operating an employment structure designed to address gender (or other) discrimination, and by requiring minimum standards of equity from the private-sector suppliers of goods and services.

Thirdly, all approaches have to be underpinned by financial and human resources. There are costs involved with all of mechanisms described, although the costs will vary in relation to how far gender is already identified as an issue. For example, countries with dedicated gender units within government may find that their costs are lower than those of others because of the availability of staff and also because of prior experience that is relevant to the situation *(16)*.

Fourthly, training needs have to be identified and met early on if any approach to gender equity is to work. Training will be essential for all of those involved in the process, from policy-makers through to front-line workers. Training will also need to be in place permanently, rather than being a one-off, in order to meet the needs of new arrivals and also to support changes in policy *(51)*.

Fifthly, it is crucial to evaluate strategies and interventions, and external evaluation is helpful in this respect. As processes are developed or systems changed, it is essential to review the impact, outcomes, costs, risks and benefits of what has happened. While there is a need for continuing review, external evaluation on a less frequent basis prevents complacency and helps to develop new ways of thinking *(7,32,42)*. It is also important to involve various stakeholders, including end users, in all stages of the strategy adopted *(22)*.

There are important differences between European countries in relation to structural constraints and baseline conditions. Political will, too, affects scope for change and the implementation of different approaches. Public-health policies across Europe have developed at different speeds, in different ways and

in different economic and political climates and these differences also affect the degrees to which various health systems adopt gender-sensitive approaches to policy.

In addition, the health of women and men, and therefore the priorities of health systems, varies across Europe: reproductive health features prominently for women in eastern European countries, for example, while cardiovascular disease is more significant in western countries *(4)*. This does not mean that gender-based approaches are unusable, but that different countries are likely to select the approaches that are most suitable given their specific health concerns.

The EU 'Open Method of Coordination' offers some mechanisms for mutual learning and cooperation, using 'soft law' and guidelines aimed at convergence in health policy and speedier adoption of common objectives (including gender equality and gender equity). Although not all countries in Europe are members of the EU, such coordination can spread beyond Member States, particularly in terms of sharing of approaches and 'best practice'.

The approaches reviewed here do not exclude methods based on the identification of other forms of disadvantage, such as social disadvantage connected with income and ethnicity. Regulatory approaches can be used, as in the United Kingdom, to address a number of forms of inequality simultaneously, while gender-sensitive indicators can include data sensitive to other forms of difference.

Gender inequalities are most damaging for groups experiencing other forms of disadvantage. Gender differences in health behaviours, for example, are found in lower-income groups but the consequences are likely to be more marked in terms of health status. Addressing gender equity brings a range of benefits, including better stewardship and more effective use of resources, while also increasing the capacity of health systems to address inequalities in a systematic way.

In noting these 'prerequisites', it is very important to note that action in relation to gender equity is nearly always iterative. Countries often begin with quite small changes – perhaps based on the above – which, in turn, are used to develop skills, disseminate knowledge and build commitment, which then promotes further change. For example, a commitment to the production of gender-disaggregated data in relation to health outcomes and experiences of health care can be relatively straightforward to obtain. If such data are disseminated so that they can be used by policy-makers and interest groups, both inside health systems and elsewhere, this can lead to the production of evidence concerning health inequalities between women and men that, in turn, supports the case for further change.

Gender-disaggregated data in Kazakhstan, for example, have been used to

identify specific health risks for women in relation to gender-based violence, reproductive health and high levels of anaemia, while data on men's health have been used to highlight the risks of alcohol use and substance abuse associated with stress, particularly in relation to unemployment and poverty *(52)*. These data, in turn, have enabled a range of recommendations for government action, including policies designed to target gender-based violence, strategies for tackling human trafficking, and funding for specialist residential alcohol services that allow men to be treated away from their homes in order to increase women's protection *(52)*. In addition, the Government has introduced an Ombudsman on Human Rights and a gender-specialist role within their offices. There is also a move to enact legislation to increase women's participation in public and political life, and to give men and women equal opportunities and equal rights.

A recent gender-based analysis of Kazakhstan *(53)* has revealed that much remains to be done to increase gender equality and to address gender equity. However, the situation in Kazakhstan serves as an example of how a country that is less developed economically than others in Europe might best attempt to address gender across a range of policies. A targeted, iterative and focused approach, rather than an attempt at large-scale change in a cultural and economic context – which might make such broad shifts in policy more difficult and more likely to fail – appears to be appropriate.

Summary

To summarize, this policy brief has identified a number of possible ways in which (European) health systems might address gender. Some of these approaches are easier than others, in terms of resources, and more likely to be accepted by both policy-makers and those implementing policy. Others require greater resources and are likely to take longer to introduce. For some countries within Europe, the measures explored here may seem difficult to consider given the current economic and cultural conditions. However, while countries such as Norway, Sweden and Scotland have introduced a large number of measures to address gender equity, it is important to recognize that they have arrived at this point over several decades during which a number of small changes have helped to identify needs and the health gap, and have demonstrated the benefits of addressing gender equity in terms of population health and effective use of resources *(6, 32, 54)*. These changes have also built capacity at various levels within health ministries in relation to developing an understanding as to how gender impacts on health. In addition, countries have benefited from the added momentum for change resulting from the influence of international and supranational organizations, including the United Nations, WHO and the EU. These approaches offer valuable opportunities for addressing gender equity in relation to health systems, for the benefit of both men and women.

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Table 1. Gender inequalities of countries in Europe, ranked by Gender Development Index (GDI) score and showing the (United Nations) Human Development Index (HDI) and (World Economic Forum) Gender Gap Index (GGI) scores/rankings

Country	HDI ranking[a]	HDI score[a]	GDI ranking (gender-related develop-ment)[a]	GDI score[a]	GDI score minus HDI score	GGI score[b]
Iceland	1 (High)	0.968	1	0.962	–0.006	0.784
Norway	2 (High)	0.968	3	0.957	–0.011	0.806
Sweden	6 (High)	0.956	5	0.955	–0.001	0.815
Netherlands	9 (High)	0.953	6	0.951	–0.002	0.738
France	10 (High)	0.952	7	0.950	–0.002	0.682
Finland	11 (High)	0.952	8	0.947	–0.005	0.804
Switzerland	7 (High)	0.955	9	0.946	–0.009	0.692
United Kingdom	16 (High)	0.946	10	0.944	–0.002	0.744
Spain	13 (High)	0.949	12	0.944	–0.005	0.744
Belgium	17 (High)	0.946	14	0.940	–0.006	0.720
Ireland	5 (High)	0.959	15	0.940	–0.019	0.746
Italy	20 (High)	0.941	17	0.936	–0.005	0.650
Austria	15 (High)	0.948	19	0.934	–0.014	0.706
Denmark	14 (High)	0.949	11	0.934	–0.015	0.752
Germany	22 (High)	0.935	20	0.931	–0.004	0.762
Israel	23 (High)	0.932	21	0.927	–0.005	0.696
Luxembourg	18 (High)	0.944	23	0.924	–0.020	0.699
Greece	24 (High)	0.926	24	0.922	–0.004	0.665
Slovenia	27 (High)	0.917	25	0.914	–0.003	0.684
Cyprus	28 (High)	0.903	27	0.899	–0.004	0.652
Portugal	29 (High)	0.897	28	0.895	–0.002	0.696
Czech Republic	32 (High)	0.891	29	0.887	–0.004	0.672
Malta	34 (High)	0.878	33	0.873	–0.005	0.661

Table 1 (continued)

Hungary	36 (High)	0.874	34	0.872	–0.002	0.673
Poland	37 (High)	0.870	35	0.867	–0.003	0.676
Lithuania	43 (High)	0.862	38	0.861	–0.001	0.723
Slovakia	42 (High)	0.863	39	0.860	–0.003	0.680
Estonia	44 (High)	0.860	41	0.858	–0.002	0.701
Latvia	45 (High)	0.855	44	0.853	–0.002	0.733
Croatia	47 (High)	0.850	46	0.848	–0.002	0.721
Bulgaria	53 (High)	0.824	50	0.823	–0.001	0.708
Romania	60 (High)	0.813	54	0.812	–0.001	0.686
Belarus	64 (High)	0.804	57	0.803	–0.001	0.711
Russian Federation	67 (High)	0.802	59	0.801	–0.001	0.687
Albania	68 (High)	0.801	61	0.797	–0.004	0.607
The former Yugoslav Republic of Macedonia	69 (High)	0.801	64	0.795	–0.006	0.697
Kazakhstan	73 (Medium)	0.794	65	0.792	–0.002	0.698
Ukraine	76 (Medium)	0.788	69	0.785	–0.003	0.679
Armenia	83 (Medium)	0.775	75	0.772	–0.003	0.665
Turkey	84 (Medium)	0.775	79	0.763	–0.012	0.577
Azerbaijan	98 (Medium)	0.746	87	0.743	–0.003	0.678
Moldova	111 (Medium)	0.708	97	0.704	–0.004	0.717
Uzbekistan	113 (Medium)	0.702	98	0.699	–0.003	0.692
Kyrgyzstan	116 (Medium)	0.696	102	0.692	–0.004	0.665
Tajikistan	122 (Medium)	0.673	106	0.669	–0.004	0.658
Turkmenistan	109 (Medium)	0.713	–	–	–	–
Georgia	96 (Medium)	0.754	–	–	–	0.666
Bosnia and Herzegovina	66 (High)	0.803	–	–	–	–

a *(14)*, b *(15)*

Table 2. WHO gender-sensitive core health indicators

Tier	Indicator	Value in European context
1 – Health status		
1.1	Maternal mortality ratio	Low
1.2	Low birth weight; boys and girls	Medium
1.3	Infant mortality rate; boys and girls	Medium
1.4	Mortality rate for ages 1–4; boys and girls	Medium
1.5	Life expectancy at age 65 years; men and women (some countries may use life expectancy at birth)	High
1.6	Rate of self-rated depression	High
1.7	Rate of self-rated poor health; men and women	High
1.8	Rate of reported domestic violence	High
1.9	Rate of reported sexual violence; men and women, by age and relationship	High
1.10	Suicide rate; men and women, by age	High
1.11	Prevalence of human immunodeficiency virus; men and women, by age	High
2 – Determinants of health		
2.1	• Percentage of population with access to potable water; rural and urban (by men and women if data available) • Percentage of population with access to adequate sanitation (by men and women if data available) • Proportion of population using solid fuel (by men and women if data available)	Low Low Low
2.2	Literacy rate for population aged 15–24 years; men and women	Medium
2.3	Percentage of population living below national poverty line (measure of feminization of poverty to be developed)	High
2.4	Decision-making on own income	High
2.5	Percentage of regular smokers in population aged 15 and over; men and women by age	High
2.6	Proportion of population aged 15 and over engaging in heavy drinking; men and women by age	High

Table 2 (continued)

2.7	Prevalence of illicit drug use in population (particularly in those aged 15–24 years); men and women by age	High
2.8	Overweight and obesity; men and women by age	High
2.9	Percentage of young people (aged 15–24 years) reporting using condom at last high-risk sexual encounter; men and women	High
2.10	Contraceptive prevalence rate (particularly in those aged 15–49 years); men and women by age	High
2.11	Access to safe abortion	High
2.12	Proportion of population aged 15 years and over receiving regular health examination within 12 months; by sex and age	High
2.13	Prevalence of anaemia in women	Medium/High
3 – Health-systems performance		
3.1	Ambulance use (medical transport); men and women by age (to be developed)	High
3.2	Rate for cataract procedures; men and women by age	High
3.3	Use of medication for cardiovascular disease; men and women by age	High
3.4	Percentage of births attended by skilled health personnel (excluding trained or untrained traditional birth attendants)	Medium
3.5	Proportion of health facilities that offer gender-sensitive, patient-centred care (e.g. rape crisis centre, voluntary counselling and testing services for human immunodeficiency virus) (to be developed)	High
3.6	Proportion of respondents (men and women) reporting being treated with respect (to be developed)	High
3.7	• average waiting time for coronary interventions; men and women • average waiting time, in primary care, for patient to see doctor; men and women	High High
3.8	Proportion of men and women accessing provider type of choice	High
3.9	Percentage of population covered by insurance; men and women by age and by gender-specific services (to be developed)	High
3.10	Out-of-pocket health expenditure; men and women	High
3.11	Not seeking or deferring care because of health-care cost; men and women	High

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