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Health systems and quality of healthcare: bringing back missing discussions about gender and sexuality

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ABSTRACT

Gender and sexuality are recognised as social determinants of health. While gender and sexuality are becoming important frameworks guiding many disciplines and studies, discussions about quality of healthcare (QHC) lack a sufficient focus on these. When QHC studies have considered gender and sexuality the primary focus tends to be on the practice of individual professionals, patients' differential health seeking behaviours or outcomes. This commentary eapplies a gender and sexuality lens to Donabedian's framework to further understand the influence of gender and sexuality in shaping QHC. The framework illustrates how the very foundations of QHC (institutional structures, processes and outcomes), can increase or reduce inequalities in QHC linked to gender, sexuality (as well as other factors). The commentary suggests practices that would reduce these inequalities. In the context of present debates over inequality in medicine, science and global health , this commentary is a reminder that health systems have a critical role to play in ensuring that QHC does not perpetuate them. .

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1. Introduction

Gender is widely recognised as a social determinant of health by the United Nations and the World Health Organisation (WHO, 2011). More recently, there has been a slow shift to recognise sexuality as a social determinant of health and wellbeing (Parker, 2007).

Gender and sexuality influence a person's ability to access and control resources, and to participate in decision-making opportunities that protect and enhance health and wellbeing (Bowleg, 2012; Cornwall & Jolly, 2009). The net result is that those people who do not conform to social norms around sexuality and gender have an increased risk of exposure and susceptibilities to avoidable suffering; disease; delays or misdiagnosis in treatment and access to resources; developing disability and co-morbidities following treatments; and death (Fundación Soberanía Sanitaria, 2019; Sen et al., 2007).

However, while gender and sexuality are becoming important analytical frameworks guiding many disciplines and studies, discussions about quality of healthcare (QHC) lack a sufficient focus on these. Within QHC studies that consider gender and sexuality, the emphasis tends to be on individual professionals' practice; on patients' differential health seeking behaviours (i.e., differences between females and males, or occasionally between heterosexual and lesbian, gay, bisexual, and transgender persons (LGBTQ); and on access to services and health outcomes. However, less attention has been paid to the broader organisational structures of the healthcare system that create inequalities. In this sense, the links between sexuality, gender, and poor-quality care are thought of as a problem of individual patients and professionals which can be "corrected" through awareness raising and training, rather than as a systemic problem deeply rooted in the structures of the healthcare system.

In this commentary, I explore the links between gender, sexuality, and quality of healthcare. I apply a gender and sexuality lens to Donabedian's framework to further understand the influence of gender and sexuality in shaping quality of care. For each dimension of the framework I suggest examples of practices that would reduce these inequalities. In the context of present debates over gender inequality in medicine, science and global health, exposed and magnified by COVID-19, this commentary is a reminder that health and care systems have a critical role to play in ensuring that QHC does not perpetuate them. This has implications for clinicians, healthcare management and policy.

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1.1. Defining sexuality and gender

Although sexuality and gender are interconnected (Cornwall & Jolly, 2009), these two terms are different but often confused. Sexuality is much more than biological sex. It is "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (. . .)" (WHO 2006).

Gender is the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for males and females, typically based on people's assigned biological sex at birth. However, many organisations (Mount Sinai Hospital, 2012; Ontario Human Rights Commission, 2019) and societies recognise that gender must be seen as a spectrum of possibilities rather than as a binary set of two categories: female/male. These concepts are reflected "in social standards, legislation, traditions, religion and so on" (GIZ, 2019, p. 16).

Traditional medical research, practice and advocacy's focus on biological sex may underplay the contribution of gender, sexual orientation (and other social factors) in shaping differences in health outcomes. Similarly, sex-specific statistics without context can perpetuate incorrect ideas of biologically determined differences between the sexes. This situation applies to the QHC.

1.2. Quality of care

The World Health Organisation (WHO, 2017) defines quality of care as "the extent to which healthcare services provided to individuals and patient populations improve desired health outcomes". Equity is a central concern for QHC and is the hallmark of high-value care (International Forum on Common Access to Health Care Services, 2003) that is, everyone – regardless of their gender, sex, sexual orientation, gender identity, race, class, religion, age, disability or place of residence – should have equal access to, and equal utilisation of, the best quality healthcare. (Oliver & Mossialos, 2004, p. 565) However, QHC assessments integrating a gender and sexuality analysis remain in the minority.

2. Methods

Since improving healthcare organisational systems is essential to achieving quality of healthcare (Fulop & Ramsay, 2019), Donabedian's framework provides the theoretical framework to identify, categorise and examine existing articles. According to this framework, and a substantial body of literature, structures, processes and outcomes are key determinants of QHC.

This is not a systematic review but rather the amalgamation of published literature that discusses the relevance of gender and sexuality for QHC. This is because literature searches of scientific electronic databases Medline, Pubmed and Google Scholar yielded few results. This is despite the fact that a growing number of resources are available to support the integration of gender (and to less extent sexuality) in health systems research and management (Morgan et al., 2016; NIHR RDS East Midlands, 2022). For instance, searching in the database Pubmed using the keywords "Donabedian" AND "gender" AND/OR "sexuality" did not yield any results. Searches in Medline yielded 21 hits and Google Scholar 38.

The few studies drawing on Donabedian's framework and concerned with gender and sexuality could be divided in two-interlinked categories: (a) Works directly related to reproduction or disorders seen only or predominantly in women or sexual and gender minority groups (LGBTQI health, sex development, gender dysphoria, HIV and family planning). But gender and sexuality are not only of concern to these fields because such inequalities have serious consequences for other health-related fields. (b) Works studying gendered inequalities in service delivery.

It is worth noting that I did not find any study that explicitly used Donabedian's framework to examine the role of the structures of healthcare systems in perpetuating existing gender and sexuality inequalities.

3. Results and discussion

3.1. Structures

Donabedian defines structures as the "physical and organisational characteristics where healthcare occurs" (ACT Academy for their Quality, Service Improvement and Redesign suite of programmes, 2008, p. 2). This includes economic, human (e.g., staff qualifications, list of professional backgrounds, formal training), and material resources including infrastructure (space) and technical resources (equipment, supplies, therapeutic options). I argue that QHC assessments of structures integrating a gender and sexuality lens have received scarce attention.

As Morgan et al. (2016, p. 1) points out, assessing the role of structures in perpetuating inequalities in healthcare requires that scholars and evaluators examine:

> whether and how gender power relations are constituted and negotiated in health systems . . . Critical aspects of understanding gender power relations include examining *who has what* (access to resources); *who does what* (the division of labour and everyday practices); *how values are defined* (social norms) and *who decides* (rules and decision-making).

Unequal structures are linked to poor performance as they create imbalances in the distribution of resources (including human resources), and "deep-rooted"

discriminatory practices, including "rules, regulations, laws and culture that govern social institutions" (Pritlove et al., 2019, p. 503).

Unequal environments create conditions that encourage a culture of sexual harassment, discrimination based on gender and/or sexuality, and do not create opportunities to advance careers and/or support employee's triple work shift (i.e., paid work, domestic work and caring responsibilities). Such conditions can cause professional dissatisfaction, feelings of powerlessness and mental and physical health problems, which leads to "poor" performance and ultimately impacts on patient care. The good news is that many of these conditions are amenable to change. Below I suggest two actions that enable positive organisational transformation.

Creation of equitable work environments. Examples include:

- *Endorsement of equitable treatment of the workforce* as a common goal (EIGE, 2016) and as a pre-requisite to deliver high-quality care (Human Rights Campaign, 2020).
- *"Fix the numbers"*: increase diversity among health science and healthcare professionals. These involves including women and men from diverse gender, socio-economic, sexual and ethnic backgrounds (Restar & Operario, 2019). A recent review on gender in science, medicine and global health by Shannon et al. (2019, p. 565) found that a diverse workforce is more likely to reflect the experiences of a diverse society thus impacting on research priorities and research questions. The same review found that gender-diverse and LGBTQ-inclusive environments "have improved productivity, innovation, decision making, and employee retention and satisfaction". The creation of diversity in institutional structures also applies to medical academics, "research committees, funding bodies, advisory and publication committees" (Sen et al., 2007, p. x).
- *Zero tolerance to sexual harassment and gender violence*. Unsafe environments lead to higher risk for hypertension, depressive symptoms, anxiety, and poor sleep. In 2019, TIME's UP Healthcare – a North American-based industry-focused healthcare initiative of TIME's UP – was created to raise awareness about the ubiquity of sexual harassment among female healthcare professionals and medical students (50%; Fiellin & Moyer, 2019). One of the main messages of this initiative was "a safe, equitable, and dignified workforce is the only way we can provide high-quality patient care" (TIME'S UP, 2019).
- *Eliminate the gender pay gap*. Female physicians earn considerably less than their male counterparts "in every internal medicine specialty" (Read et al., 2018, p. 658). In academic circles, female medical faculty staff also earn less although "they make up 37% of the workforce and are relatively absent at higher ranks" (Fiellin & Moyer, 2019, p. 127). To my knowledge, pay gaps between heterosexual and LGBTQ people are unknown.
- *Provide clear processes to support professional advancement* for gender diverse and LGBTQ (Human Rights Campaign, 2020; Sánchez et al., 2015) professionals through mentorship schemes, networking opportunities, and work-life arrangements. The Global South Women in Surgery Africa, COACh-Cameroon and the Higher Institute for Growth in Health Research for Women Consortium, for instance, have trained women health practitioners, trainees and scientists in applying for grants, leadership, ethics, research quality, and project management (Odera et al., 2019; Tiedeu et al., 2019, p. 505).

3.1.1. Development of support structures

Examples of actions to develop support structures that promote an evidence base for equitable policies and interventions include:

- *Make funding bodies sensitive to gender and sexuality* by increasing the diversity of professionals in the panels, equity-proofing with regard to which health topics get researched (Sánchez et al., 2015) and requesting mandatory questions on how bio-physiological processes are linked to wider socio-economic conditions including inequalities on the basis of sexuality and gender (Johnson et al., 2014; Witteman et al., 2019).
- *Strengthen the quality of peer review*. Build the capacity of authors, editors and reviewers to detect and challenge bias in research questions, methodologies, and analysis (Ariño et al., 2011). The Gendered Innovations Project (Gendered Innovations, 2019b) at Stanford University has collated a list of journals that have developed guidelines for authors and reviewers to conduct gendered analyses when selecting papers for publication.
- *Strengthen the curriculum* and professionals' knowledge through the incorporation of gender and sexuality analysis in university degrees, ongoing training and career development opportunities (Ruíz-Cantero et al., 2019).

3.2. Processes

In Donabedian's terms processes are defined as how resources are used or "how systems and actions work to deliver the desired outcome" (ACT Academy for their Quality, Service Improvement and Redesign suite of programmes, 2008, p. 2).

An important body of research has studied inequalities in QHC as a the result of wider gendered and sexuality inequalities within processes delivered to patients, such as services, diagnostics, or treatments (Chilet-Rosell et al., 2009, 2009; Ruíz-Cantero, 2019; Ruíz-Cantero et al., 2019). An oft-cited article by Ruíz-Cantero and Verbrugge (1997) showed the coexistence of two biases in medicine, which affect processes. The first assumes that women and men's disease risks and expressions are the same. A case in point is the persistent exclusion of women in clinical trials since it is erroneously presumed that the safety and efficacy of therapies tested on men can be extrapolated to women, posing serious risks to women's health. Sixteen years after Cantero's article was published, another study concluded that "Women and racial/ethnic minorities remain severely underrepresented in cancer clinical trials" (Kwiatkowski et al., 2013).

The second bias assumes biological differences between women and men which have not been scientifically proven, often reproducing sexist stereotypes. An example is the knee biotech industry's overemphasis on biological differences between men and women's knees for commercial purposes. Challenging this assumption, Blaha et al. (Gendered Innovations, 2019a) argue that the patient's height or a surgeon's experience of installing a prosthesis is more important than their biological "sex". This bias could lead to waste of economic resources and poor health outcomes since a "female knee may be a poor fit for some women and a good fit for some men".

Esteban-Galaza (Esteban, 2006) notes that a third bias is the systematic conflation of gender with women. The net result is that what Luciano Fabbri (Fabbri & Fundación Soberanía Sanitaria, 2019, p. 111) terms "institutional blindness to men's health needs". More specifically, men's needs have been handled mostly in terms of regulation of violence and risk prevention (e.g., occupational health, addictions and sexual behaviour). This approach to men's health glosses over calls for more holistic conceptualisations of health and wellbeing.

These biases point to a less-studied aspect of processes in QHC which is the research apparatus which influences, and is influenced by, practice. Systemic gender and sexuality bias is expressed in the realm of ideas and knowledge processes through research priorities, research questions, hypotheses, sampling, choice of methods, analysis, evaluation and dissemination (Inhorn & Whittle, 2001). It remains debatable whether approaches to assessment processes in QHC examine the extent to which the intersection of biological sex, sexual orientation, gender identity and roles (Ruíz-Cantero, 2019) is systematically considered in all aspects of research (see, Ritz & Greaves, 2022). It should also be noted that the perspectives of LGBTQ and gender non-conforming professionals and service users/patients have also been consistently excluded by research and healthcare planning, and as a result their specific health needs have been unaddressed (McDermott et al., 2018; Taylor & Bryson, 2016).

Process measures indicate what services, policies or interventions do to maintain, or improve outcomes. Yet, these metrics rarely include an equity focus which is sensitive to gender and sexuality (and other social factors) and may mask inequalities experienced by different population groups that emerge from processes.

There are a range of tools and guidance that can be used to assess whether processes are sensitive to gender and sexuality. Although these toolkits have not been necessarily designed for QHC, and tend to focus on gender only, they are relevant if used flexibly to account for other factors that create inequalities in QHC. For instance, International Planned Parenthood Federation (IPPF 2019) proposes a useful toolkit to assess how health organisations, services and programmes are responding to gender issues. Other tools include The Gender Awakening Tool (Nieuwenhoven et al., 2007); the Gendered Innovations project (Gendered Innovations, 2019b), Sex and Gender in Systematic Reviews Tool (Doull et al., 2011) and Gender in EU Funded Research Toolkit (European Commission, 2011).

3.3. Health outcomes

Health outcomes are a marker of QHC. As explained above, the methodological and epistemic blindness leads to systemic inequalities in service design, prevention strategies and care. There is a wealth of evidence showing how these inequalities in healthcare processes produce systematic differences in health outcomes between different socio-economic groups which are strongly affected by gender and sexuality. Gendered and sexuality inequalities in patients' outcomes can be seen in any field of health including oncology, cardiology, pharmacology, osteoporosis, and liver diseases just to name a few (Hawkes et al., 2020; Ruíz-Cantero, 2019; Ruíz-Cantero & Verdú-Delgado 2004; Sen et al., 2007; WHO, 2022a, 2022b).

It is important to recall that these inequalities intersect with other social inequalities and are "unfair, unjust and avoidable" (Krieger, 2001, p. 698). Thus, it is fundamental to track the health impacts across social groups to ensure QHC does not reproduce inequalities. Two recommendations to track impact and drive improvement include developing gender and sexuality-sensitive evaluations and actions on the structural determinants of health.

3.3.1. Developing gender and sexuality sensitive evaluations to assess QHC

Healthcare services, interventions and policies have the potential to increase health inequalities through a range of intersecting factors, such as gender, sexuality, age, disability, ethnicity, etc (O'Neill et al., 2014). Inequalities occur when an action widens the gap between social groups.

A core element of quality improvement is monitoring and evaluation from the very start of planning. More importantly, evaluation frameworks should capture information on the differential impact of structures, processes and outcomes by gender and sexuality, as well as other factors (European Commission, 2018, p. 3; Hosseinpoor et al., 2018) to determine equity in outcomes. Also, the evaluation should generate evidence for what is working for health equity and what is not. Only this way we can improve practice and policy to tackle inequalities in QHC.

3.3.2. Advocate for action on the structural causes of gender and sexuality inequalities that harms health

As it can be inferred from above, inequalities in health are often the result of social and economic inequalities, rather than deficiencies of the health system (Payne, 2009, p. 6). Satcher et al. (2013) suggest that meeting the population's health needs also requires eliminating the social inequalities that make people ill in the first place. Within QHC, this means moving beyond the focus on improving access and care delivery to addressing the root causes of disease. Achieving this can no longer be the *sole* responsibility of public health, social policy and politicians. QHC professionals can make major contributions to this aim by building local partnerships to act on the root causes of inequalities, for example, with Local Authorities, Third Sector organisations or medical–legal partnerships (Gupta et al., 2019).

Collaborative partnerships may yield another benefit. The relentless impact of inequalities in patients' health is wreaking havoc on the mental and physical wellbeing of health professionals by creating "moral injuries". Moral injury describes professionals' feelings of powerlessness, disenchantment and frustration with medicine as it "fails" to "provide high-quality care and healing in the context of healthcare" and increasing inequalities (Talbot & Dean, 2018). Health practitioners and researchers have emphasised the positive effects of collective work to address the social determinants of health for their wellbeing (Hansen & Metzl, 2019).

4. Conclusion

Discussions linking QHC, gender and sexuality do not abound. The existing ones – albeit not always explicitly named as QHC – have to date been largely focused on differences in patients' health-seeking behaviours, biased practices of professionals, and improving access and delivery of services. This commentary draws on Donabedian's framework to explore the influence of gender and sexuality in shaping quality of care. The framework highlighted how the very foundations of QHC – namely institutional structures, processes and outcomes – play a determinant role in increasing or reducing inequalities in QHC. For each dimension of the framework the commentary suggests examples of practices that could be adapted to address the negative impact of gender and sexuality-related inequalities. While this commentary is not a systematic review, it includes relevant real-world examples hoping to encourage health systems managers, practitioners and researchers to apply a sexuality and gender lens to enhance quality improvement at different levels of the system.

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Declarations

I declare that this research has not received funding from any source. This commentary does not deal with animal or human subjects and so does not require approval by an Institutional Review Board (IRB) or Ethics Committee.

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