# PUTTING GENDER ON THE NHS AGENDA:

Implementing the gender equality duty in the NHS

**Report of the conference**
held on Monday 6th November 2006

**This conference was organised by**

MHF MEN'S HEALTH FORUM

Communities and Local Government

DH Department of Health

Women. Men. Different. Equal. Equal Opportunities Commission

**with:**
**Essex Primary Care Research Network and NHS Employers**

These partners designed and funded the event. However, this report has been produced by the Men's Health Forum based on the presentations given by speakers and debate generated at the conference and does not necessarily represent the views of any of the organisations who funded, designed and organised the event.

# PUTTING GENDER ON THE NHS AGENDA:

## Foreword

We've come a long way…

"It's enormously gratifying to me that this important piece of public policy will encourage new thinking about gender – and about how we are going to provide services better." Angela Mason, head of the Woman and Equality Unit at the Department for Communities and Local Government.

*"This is not about having an all-singing all dancing plan that just sits on the shelf. It is a legally enforceable duty."*
*Jenny Watson, chair of the Equal Opportunities Commission.*

Public sector organisations will be responsible for the implementation of new gender equality duties from April 2007. These duties will be introduced under the terms of the Equality Act 2006. There is a general duty on the public sector to promote equality of opportunity between men and women and, for statutory health bodies, an additional set of specific duties which include the production of an equality scheme as well as gender impact assessments of all major policy developments.

The new duties require a radically different and innovative approach to equality. Achieving gender equality is no longer a matter primarily relating to pay and employment; it now extends across every aspect of an organisation's activity, including service planning and delivery.

The act will represent a considerable challenge to organisations. Men's Health Forum and Equal Opportunities Commission research suggests that there is, as yet, relatively little systematic activity to promote gender equality in the health field. There is also, crucially, a generally limited understanding of what gender means beyond, at best, maternity services for women and prostate cancer services for men. Additionally, the Act has significant implications for males – they constitute a particularly disadvantaged group in many areas of health yet they currently benefit from very few examples of effective 'gender-sensitive' services.

This report is part summary of a one-day conference held in London on 6 November 2006, just five months before the gender duty was due to become law, to see how this will impact on the services the NHS provides to patients. The event was the first to look at the impact of the gender equality duties on the planning and delivery of health services.

were still struggling to understand the difference between a person's sex (a biological fact) and their gender (the socially constructed roles for men and women).

We hope this will be more than just a conference report. We want it to be a resource all NHS staff can use to help inform the debate, to help understand what is meant by gender equality and to guide managers on what needs to be done.

One key finding emerging from the conference was that gender equality is not a competition between men and women. While initiatives to reach men specifically – health checks in barber's shops for example – may well help, the gender duty is more than just that. It's about embedding the concept of gender equality – as with race equality, or eliminating age discrimination – deep into the heart of the NHS. It is about considering the needs of both women and men across the board.

As health minister Rosie Winterton, who spoke at the conference, said, "It's about getting people to think about it right from the word go." And that, she added, "is quite a challenge."

Let's hope this document helps the NHS rise to that challenge.

**Professor Lord Kamlesh Patel of Bradford**,
conference chair.

## What is gender?

*"When they think of gender they think of the dangly bits for men and the reproductive bits for women. If you can get people beyond this it's a great step forward."*
Professor Alan White, Centre for Men's Health, Leeds Metropolitan University and chair of the Men's Health Forum.

It was Alan White, the world's first professor of men's health and one of the first speakers of the day, who set out to define gender.

It's about more than how men and women appear physically – which is our sex, he explained. Gender is socially determined: it's about the way we live our lives. Gender, rather than our sex, affects the way we see ourselves, the way we interact with others, and the way we access health care, he said.

"We've been told how we should behave from an early age, about how we should perform," said Alan. It could be as simple as the 'big boys don't cry' message given by a father or mother to their son. Or it could be the advertising on television that encourages women to be slim and wrinkle-free.

Understanding male gender – or masculinity (in fact, 'masculinities' is the term now used by many sociologists to take into account differences between different groups of men) – is crucial to understanding men's health. It helps to explain, for instance, why so many men take risks with their health – because risk-taking is one way males are brought up to prove their maleness to each other and themselves. It helps to explain why men are often reluctant to seek help – because help-seeking is widely interpreted as a sign of weakness whereas males are 'supposed' to be strong and always in control.

There is also evidence that men's relationship with their own bodies affects their health attitudes and behaviour. Men expect their bodies to be capable of doing 'manly' things and not to be weak or vulnerable. Many also perceive their bodies as mechanical objects and see health care as 'fix-it' cure and use analogies such as going to the plumber to fix a leaking tap or a garage to get the car repaired.

Understanding gender can help the development of more appropriate services for men. For example, because men are not 'allowed' to reveal weakness publicly, providing them with the means of accessing health information anonymously and confidentially (e.g. via telephone helplines or websites) might prove useful to many. Health promotion materials that use the metaphor of body as machine could also be more appealing to many men. It is clear that health services cannot meet men's needs by simply opening the doors of traditional services, especially primary care, and expecting them to walk through. A different approach is needed.

Giving examples of health problems that are gendered Alan also explored how the differences in the way that men and women both experience and react to their health challenges influences decisions that both the lay public and even professional groups act.

**Gendered health problems include:**

- Coronary Heart Disease
- Mental and emotional health problems
- Overweight and obesity
- Cancer
- Sexually transmitted disease
- Domestic violence
- Autoimmune illnesses ie diabetes, multiple sclerosis

Focusing on coronary heart disease (CHD) and mental health he demonstrated how our current perceptions of these illnesses are skewed either by the male presentation, as in CHD, and women's in the case of many mental health conditions. This, he argued, can lead to misdiagnosis by professionals and also a failure by both men and women to recognise the risks, often with dire consequences.

## What are the implications of the new gender equality duty?

*"It's a duty to think carefully – not to go along with assumptions. It will mean all public authorities will have to promote equality of opportunity. It's a proactive duty. We want outcomes, not processes. This is about getting things done."*
Angela Mason, Head of the Women and Equality Unit, Department for Communities and Local Government.

*"There is only one way we can improve the health of our population and that is by health services that are available for everybody. If we can't have that, we will never have equality in health."*
Rosie Winterton, Health minister

When the gender equality duty comes into force, in April 2007, public bodies – including the NHS – will have to "actively promote equality between men and women".

It's a challenge, as health minister Rosie Winterton acknowledged during the conference – one requiring a change in attitude as much as anything. But she saw it as essential to promoting equal access to health care for all.

There are many ways in which public bodies will be expected to demonstrate they are actively promoting gender equality. They include having an understanding of the impact of their work on men and women as distinct groups and consulting and engaging people from the local community in making decisions and policies on issues that affect them as men and women.

There are specific requirements for the NHS to demonstrate they are in compliance with the law. These include:

- Producing and publishing a gender equality scheme in consultation with stakeholder groups, and reviewing it every three years;
- Conducting and publishing gender impact assessments covering all major proposed developments in policies and services.
- Considering gender equality issues at the beginning of policy making, assessing the likely impact of policies on men and women, and ensuring that policies promote gender equality.
- Ensuring that contractors (including GPs and pharmacists where they are contracted) carrying out public functions on behalf of the NHS also implement the new duties.
- Collecting data on service users' needs, satisfaction levels and outcomes, broken down by gender.
- Taking account of any evidence that men and women have different needs, experiences, concerns or priorities when developing policies and services.
- Ensuring that women and men make greater use of services that their sex had previously under-used.

The NHS will also have a duty to ensure all relevant staff understand the new duties and their implications.

For more information, visit the Men's Health Forum website www.mhfgenderduty.org.uk or for a more detailed explanation visit the Women and Equality Unit website www.womenandequalityunit.gov.uk.

As Angela Mason, head of the Woman and Equality Unit at the Department for Communities and Local Government, told the conference: "It's not about just having a scheme [for men's or women's health]. You have got to have an action plan. It is critical this is drawn up with the relevant stakeholders. We want outcomes, not processes. This is about getting things done."

## Why bother?

There are some fundamental reasons why the NHS needs to address gender issues, as Professor White illustrated.

He cited differences in men's and women's experiences of coronary heart disease, mental and emotional problems, overweight and obesity, cancer, sexually transmitted diseases, reproductive health, and of auto-immune system diseases.

For instance, there are differences in the way men and women perceive pain, and women's experience of heart disease can be very different from men's. Women typically present to their GP with different symptoms – shortness of breath, weakness, fatigue, cold sweat and dizziness - while men report chest pain, pain radiating from the left arm, and a feeling of acute indigestion.

"Weight is a gender issue," he said, suggesting that to most doctors, as a tall man who did not appear to be carrying too much weight, he would not appear to be at risk of obesity. "But I have 39 inch waist and that means I'm almost into the high risk category. I should be worried about my weight.

"With sexually transmitted diseases, almost all the effort is focussed on women, when half the problem is men.

"The principle cause of men dying from many diseases is that men delay seeking help. Maybe it is because they are so in awe of the health professionals, or that they don't see the symptoms as being serious enough to merit attention."

The point to understand, he said, was that it should not become a competition to see which of the two sexes is the worst off. "We need to think about targeting all men across all healthcare provision and all women across all healthcare provision."

## So where we up to?

*"Gender is one of the things that is so fundamental, we've managed to ignore it,"*
David Wilkins, Policy Officer, Men's Health Forum.

At the time of the conference, progress in developing gender-sensitive policies and services had been slow if not non-existent. While there are some innovative local schemes aimed at men or women, many of these happen despite rather than because of the system. They have been developed by individuals who have a vision about what could be done to improve the health of men and women, and who have been fortunate to secure funding – often short term. Only rarely is gender an integrated part of a health organisation's strategy, as research by the Forum shows.

David Wilkins, the Forum's policy officer, outlined the results of research by the Forum and Essex Primary Care Research Network. They carried out a snapshot survey in the spring of 2006, and then undertook case studies of five specific primary care trusts (PCTs).

The picture was not encouraging – though unsurprising to the Men's Health Forum.

Only 15% of PCTs responding said they consciously tried to ensure that the services they provided or commissioned were delivered in such a way so that would be used by men and women in direct proportion to differences in needs.

Only 31% said they 'always' used cancer data that was disaggregated by gender in their PCT's planning and decision-making.

## So what needs to be done?

*"Data should always be collected in a disaggregated form."*
David Wilkins, Men's Health Forum policy officer.

A range of measures can be taken to demonstrate a trust is taking account of gender in planning and delivering its services. One of the simplest and least expensive is to break down existing data by gender – and find out the extent of the problem.

"Data should always be collected in a disaggregated form," said David Wilkins. "And the information given to the public should also be broken down by gender."

Health minister Rosie Winterton agreed it was vital to have relevant health statistics available disaggregated by gender:

"That's key to making sure the health care professionals can make suitable decisions. Unless that data is there, it can be quite difficult to make sure you are making the right decisions," she said.

"Monitoring is going to be an important part in making sure some of these health inequalities are being addressed," Ms Winterton added.

David Wilkins also recommended that there should be a 'gender lead' within SHAs; training should be made available for staff; and that PCTs should set up local advisory groups to feed into good practice.

The Department of Health should also set up its own advisory group to scrutinise progress nationally. A national database of good practice was also needed, he suggested.

## The potential barriers

### 1. Where's the cash?

*"We have got to be clear - this is something about which we can't say 'we can't do this unless we've got the money to do it'."*
Rosie Winterton MP, minister of state for health services.

Time and again throughout the day, delegates kept coming back to the issue of resources – or lack of them. "Do we have to wait to get to a position where money follows the equality agenda?" asked one delegate from a London PCT. "Isn't that the only way to get things done at the end of the day?"

David Wilkins recognised the problem – but argued money alone was not the sole answer:

"What is going to make the difference is people understanding the issues and taking it upon themselves to scrutinise what is going on.

But some of the projects around men's health, such as the highly successful Bradford Health of Men project, had a cash question mark hanging over them. "They are coming to the end of the five year funding for the project," said Professor Alan White. "Are they going to be continued, or are they going to be split up?"

Despite criticism from the audience over the lack of resources, Ms Winterton would not accept that this alone was a barrier to the gender duty implementation.

"There's a tendency to say if can't put the resources there, it won't happen. In fact there is quite a lot that can be done. People say it's about resources, but it must be deeper than that. There must be some reason why they don't feel empowered to do it. Maybe they don't know how to. Maybe there isn't enough guidance out there?

### 2. Changing hearts and minds? Or merely ticking boxes?

*"It sometimes means changing people's approach, which is quite a challenge. It isn't just about the government ticking the boxes.*

*I do believe if we deliver gender specific health services to patients we can actually make a difference to the quality of service we offer."* Rosie Winterton MP

Many delegates at the conference – who were already struggling to ensure compliance with the race equality requirements – feared that, without earmarked funding for the gender initiative, it would become nothing more than a tick box exercise.

But there will be checks on how compliant NHS organisations are, said health minister, Rosie Winterton, who was determined this needed to be about much more than just ticking boxes.

The newly created Commission for Equality and Human Rights will carry out a scrutiny of how well the duty is being implemented, supported by the Healthcare Commission, she explained.

The Healthcare Commission already has a similar role in overseeing the implementation of the Race Equality Act – and has recently produced a damning report on the poor progress to date. Just how effective a stick this will be to beat NHS organisations remains to be seen though, warned Surinder Sharma, the National Director for Equality and Human Rights at the Department of Health (see Race and Gender, below).

Ms Winterton acknowledged it would not be an easy task. "We have to start right from the word go when we are devising policies," she said. "We need to make sure we are looking at them from a gender point of view. It sometimes means changing people's approach, which is quite a challenge."

She accepted a major change was needed among healthcare professionals: "If we are to achieve this, we need a radical culture shift across the healthcare sector. And I'm including the Department of Health in that."

Delegates suggested that gender issues needed to be to the fore in the public health agenda; that gender equality should be part of the chief executive's job description; and doctors' training on men's and women's health should be increased. It was also suggested that research should only be funded if it included a gender analysis.

### 3. Can better commissioning help?

Inevitably, yes, concluded the workshop led by Stephen Morris, commissioning advisor at the Department of Health.

But it wasn't always that straightforward. He accepted that, despite the requirements of the Race Equality Act, every NHS organisation was currently not fully complying with that legislation. And the sad irony of this, he suggested, is that many people had chosen to work in the NHS because they saw it as an organisation that is more open to equality issues than most.

While central government was keen to impose targets in order to improve the health of those living in England, he suggested there had been "no value infusion" among local leaders.

But he said the government's approach of ensuring any new service was tried and tested before being fully implemented was an effective one in the gender equality debate. "If you know it is a problem, you need to understand why it is a problem," he said.

PCTs' responsibility to ensure that contractors carrying out services for the NHS complied with the duties was also highlighted. This will be especially important when commissioning services from GPs.

**4. Race and gender: what lessons have been learnt?**

*"In all of this, what is missing is leadership commitment. It sits somewhere separately, like human resources, but it has to be part of the organisation. If it doesn't it will fail."*
Surinder Sharma, National Director for Equality and Human Rights at the Department of Health.

"A lot of work has been done to promote race equality across the NHS and I hope the same will be said for the gender duty, said health minister Rosie Winterton. But the Department of Health's National Director for Equality and Human Rights, Surinder Sharma, was less convinced of the progress on race – and wanted to ensure the same didn't happen with gender.

He has been monitoring progress on the implementation of the Race Relations (Amendment) Act 2001 that already places a duty on the NHS to take account of race in service provision, similar to the duty which will be implemented for gender equality in April 2007. The Healthcare Commission recently issued a damning report on poor progress to date over race.

"In all of this, what is missing is leadership commitment," said Mr Sharma, to applause from the audience. "They all agree this is the right thing to do, but when we talk to them three months' later, leadership is totally missing. That's because it is not a performance management issue. They are not assessed for this – so it is not keeping them awake at night. It sits somewhere separately, like human resources, but it has to be part of the organisation. If it doesn't it will fail.

"There has got to be expertise within each of the trusts. There has to be an infrastructure. This should no longer be within human resources, but within finance and strategy."

He acknowledged you couldn't ask the NHS to do 50 things at once, but that it had to look at only four or five.

He suggested the priorities for NHS trusts should be:

- carrying out an impact assessment
- developing a single equality scheme

- ensuring leadership accountability
- embedding the duty in the fabric of the organisation
- giving boards responsibility for monitoring equality and having senior managers to champion it.

"Unless you get some of these key things happening, we will still be here in the next five or ten years, as we have been on race for the last 20 years," he warned.

## Gender and Specific Patient Groups

### Understanding the differences

Traditionally, the NHS was built around providing care for women and children. But from a male health perspective, it would help if there were better access to GP surgeries, such as evening and weekend opening hours. With twice as many men in full time work as women, this group was the most likely to find it hard to get to the doctor's outside conventional work hours, said the MHF's policy officer, David Wilkins.

He also suggested the government look into why take up of the pilot for the national Bowel Cancer Screening Programme achieved only a 51% take up among eligible men, compared to 61% in women. And PCTs could look into why men are three times more likely to take their own lives, why 78% of drugs related deaths are among men, and why twice as many boys as girls are killed in pedestrian road incidents.

He called for more examination of the way services were provided for men and for women.

"I don't think we know, for instance, whether female health professionals are more effective with women [in providing health care] and males are more effective with men," he said.

### Meeting the gender needs of older people

*"Men are much more likely to use the car as their main form of transport. 70% of all men over 65 owned or used a car, compared to under 50% of women."*
Dr Emanuela Sala, Essex University

Researchers Professor Ruth Hancock and Dr Emanuela Sala from Essex University and the Essex Primary Care Research Network outlined their analysis for the Equal Opportunities Commission of the General Household Survey and the 2001 census, which they used to give some pointers about the gender differences of the 65+ age group and their needs.

It showed that women were more likely to live in residential institutions than men (6% of women against 3% of men) and that 46% of the women were widowed, compared to 17% of the men. Men were slightly more likely to have had an outpatient visit in the last three months (24.7% of men; 22.5% of women).

However they were less likely to have seen a GP (19.4% of men had done so in the last three months; 22.2% of women had done so.)

The use of transport was a significant issue. “Where we found the most difference was in use of transport,” said Dr Sala. “Men are much more likely to use the car as their main form of transport. 70% of all men over 65 owned or used a car, compared to under 50% of women.”

If the women lived with or were married to a man who owned a car, transport was not a problem, but if they were single or widowed, it immediately was one.

The research also showed that those people living as couples tended to have more caring responsibilities than those living on their own. Gender differences were often unexpected and challenged assumptions: in the 75-84 age group, for instance, men were more likely to be providing care for someone than a woman (12% of men compared to 8% of women.)

In terms of policy decisions, it needs to be recognised that older women are more likely to be living on their own than older men.

“But this is changing,” said Professor Hancock, referring to high divorce rates. “We will see a reduction in the number of older people living as married couples. There is quite a lot to think about there for policy.”

**Meeting the gender needs of men and women with mental health problems**

The issues around women’s security in mental health units have long been to the fore. But sometimes the answer lies not in new services, but in reorganising those already available, suggested Jennifer Paul, Joint Lead on National Gender Equality and Women's Mental Health, who was co-leading one of the sessions with Jenny Bywaters, senior public mental health advisor with the Care Services Improvement Partnership.

Those attending the workshop spoke of various local initiatives to address gender equity. Derbyshire PCT ran a half day training course in women and mental health; another had carried out a survey of clients with learning difficulties and mental health problems, which mainly had replies from females.

One workshop member spoke of plans in her trust to trial a women-only ward, although many of the women they had spoken to were happy to be on a mixed ward – as long as they had their own bedroom and en-suite toilet. The women didn’t have to walk along a communal corridor in the night. Another member of the group reported that one of the biggest difficulties for newly arrived patients was not around gender, but about identifying who was a member of staff and who was another patient.

## The role of primary care

The role not just of the GP but of the pharmacist in providing more gender-sensitive health care came under the spotlight in one working group, led by Dr Ian Banks, a member of the BMA's council, and Graham Phillips, of Manor Pharmacy Group.

Men should find it easier to get to a pharmacist than to a GP surgery, they suggested, because of the longer opening hours and the fact they didn't need an appointment. More could be done to help men – and women – realise that the pharmacist could help with many problems, rather than having to go to the doctor.

Dr Banks even suggested that schools should teach pupils how to access a GP as part of the national curriculum, to encourage men to seek help when they had a medical problem.

## Don’t be caught out!

For many NHS trusts, the gender equality duty may feel like yet another thing to have to worry about. The real worry is that trusts fail to comply – and then face a test case from an aggrieved patient.

Jenny Watson, chair of the Equal Opportunities Commission, told the conference: “The key outcome I would like to see is at the start of any policies, the NHS looks at what the needs of women and men are.

> *“This is not about having an all-singing all dancing plan on the shelf. It is a legally enforceable duty.”*

The Equal Opportunities Commission will be working with the Healthcare Commission to monitor adherence to the act. First, it will be asking when each trust’s gender equality scheme is going to be published.

If you’d like further advice on how your trust can fulfil its duties under the Equality Act, then contact any of the following organisations:

- Men’s Health Forum: www.mhfgenderduty.org.uk
- Women and Equality Unit: www.womenandequalityunit.gov.uk
- Department of Health Equality and human rights: http://tinyurl.com/ozkb4
- Equal Opportunities Commission’s gender duty pages*: www.eoc.org.uk/Default.aspx?page=15016
- NHS Employers: www.nhsemployers.org

* In October 2007 the Commission for Equality and Human Rights will take over the work of the EOC including monitoring compliance with the gender duties. www.cehr.org.uk.

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