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"Striving for Improvement:
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in European Female Health Care"

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Pledge of Honesty:

"On my honour as a student of the Diplomatic Academy of Vienna, I submit this work in good faith and pledge that I have neither given nor received unauthorized assistance on it."

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"Whenever you include a group that's been excluded, you benefit everyone. When you're working globally to include women and girls, who are half of every population, you're working to benefit all members of every community. Gender equity lifts everyone. Women's rights and society's health and wealth rise together."[1]

- Melinda French Gates

[1] Gates, M., 2019. *The moment of lift: How empowering women changes the world*. Flatiron Books, p.24.

Abstract – English Version

This thesis argues that a gender-equity focussed approach on European health care, versus a gender equality approach, is the only viable solution to effectively address female health needs. Women's health has historically been neglected – both in practice and medical research – which led to inequalities in access and service, but also created a lack of understanding of the health care required specifically for the female reproductive system. This will be discussed on the basis of policymaking at the European level, gender studies and feminist studies, drawing on medical literature where necessary to highlight biological needs for women specifically.

The thesis contains a comparative analysis between two countries which are actively working towards changing the lack of gender equity in their health care systems, namely the United Kingdom and Spain. These two countries were selected owing to the focus topic of female health being the same, namely related to menstruation.
The two countries are both front-runners in specific areas of menstrual health and set positive examples of first steps that can be implemented by other countries to start working towards gender equity in health care. However, both lack a specificity and measurable outcomes for their policy recommendations for working towards gender equity in favour of women's health care.

To effectively address female health needs and achieve gender equity in the long-term, the key starting point is education – both featuring female health in greater detail in medical education and research, as well as adapting the education system to incorporate a greater focus on female health needs for both female and male students. In addition, female health policies must be created or made a focal point until key systems and processes are altered in such a way that encourages and strengthens the recognition that female health requires and deserves specialised and adapted health care.

Abstract – Deutsche Version

In dieser Masterarbeit wird argumentiert, dass ein geschlechtergerechter Ansatz in der europäischen Gesundheitspolitik im Gegensatz zu einem Ansatz der Gleichstellung der Geschlechter die einzig praktikable Lösung ist, um den Bedürfnissen von Frauen adäquat gerecht zu werden. Die Gesundheit von Frauen wurde historisch gesehen immer schon vernachlässigt - sowohl in der Praxis als auch in der medizinischen Forschung - was nicht nur zu Ungleichheit bei Zugang und Leistung führte, sondern auch zu einem mangelnden Verständnis der speziell für das weibliche Reproduktionssystem erforderlichen Gesundheitsversorgung. Dies wird anhand von drei Gesichtspunkten erörtert; die da wären Politikgestaltung auf europäischer Ebene, Gender Studies und feministische Studien erörtert. Immer wieder wird hier auf medizinische Literatur zurückgegriffen, um die biologischen Bedürfnisse von Frauen aufzuzeigen.

Die Arbeit enthält eine vergleichende Analyse zweier Länder, die sich aktiv um eine Veränderung der mangelnden Geschlechtergerechtigkeit in ihren Gesundheitssystemen bemühen, nämlich das Vereinigte Königreich und Spanien. Diese beiden Staaten wurden aufgrund des Schwerpunktthemas, welches in beiden Fällen die Menstruation ist, ausgewählt. Beide Staaten sind Vorreiter in bestimmten Bereichen der Menstruationsgesundheit und stellen positive Beispiele für erste Schritte dar, die von anderen Staaten umgesetzt werden könnten, um die Geschlechtergerechtigkeit in der Gesundheitsversorgung voranzutreiben. Beide erwähnte Beispiele weisen jedoch einen Mangel an konkreten und messbaren Ergebnissen auf, die für ihre politischen Empfehlungen zur Förderung der Gleichstellung der Geschlechter in der Gesundheitsversorgung von Frauen sprechen würden.

Um die gesundheitlichen Bedürfnisse von Frauen wirksam zu verändern und langfristig Geschlechtergerechtigkeit zu erreichen, ist der wichtigste Ansatzpunkt die Bildung - sowohl die ausführlichere Behandlung der Frauengesundheit in der medizinischen Ausbildung und Forschung als auch die Anpassung des Bildungssystems, um die Bedürfnisse der Frauengesundheit sowohl bei weiblichen als auch bei männlichen Studierenden stärker zu berücksichtigen. Darüber hinaus muss eine Frauengesundheitspolitik geschaffen oder in den Mittelpunkt gerückt werden, bis die wichtigsten Systeme und Prozesse so verändert sind, dass die Erkenntnis, dass Frauengesundheit eine spezialisierte und angepasste Gesundheitsversorgung erfordert und verdient, gefördert und gestärkt wird.

A precious asset – Health reimagined

Introduction

Women have been considered less important in health care to men since Ancient Greece.[2] For centuries, female health has been underrepresented in clinical studies, research, scientific development, and policy making. This discrimination is not merely based on sex – it is highly intersectional: women of colour, indigenous and Asian women are statistically less likely to receive the care that they need, be this misdiagnosis or lack of attention to the patient's symptoms by medical professionals. Women in lower socioeconomic circles are more likely to be treated incorrectly or not visit a medical professional in the first place. Thus, health is more than physical well-being – health is deeply and intricately related to race, sex and gender, socioeconomic status – especially for women.

This thesis will discuss the opportunity for a novel approach to European health policy, posing the research question:

How would the female population of the European area benefit if a gender equity approach was adopted into national health care policy?

The idealistic goal is that this thesis and additional research into this field will demonstrate that enhancing the current policy with gender-specific policy changes is the only viable, long-term solution in the health care sector going forward in the fight for genuine equality between men and women. Prior to explaining the relevant subject areas there are three definitions that need to be made:

Firstly, it is important to highlight that for this thesis, the terminology used will be based on a gender binary – 'male' and 'female', respectively 'men' and 'women'. This is purely due to the nature of the academia and scholarship available in this field at the present moment and the limitation in the length of this thesis. Due to these limitations, male health, and the health of those who fall along the spectrum between male and female will not be explicitly discussed. The focus will be placed on female patients (described as 'woman' or 'women') who are biologically female.[3] As research, science and policy progressed in the field of medicine, social

[2] Perez, C.C., 2019. *Invisible women: Data bias in a world designed for men*. Abrams, p.170.

[3] 'Biologically female' in this context refers to those persons who have xx-chromosomes and female reproductive sexual organs, as this is relevant to this specific health-based discussion.

science and policymaking, the intricacies of gender will be – and ought to be - taken into more consideration.

Secondly, 'female health' in the ambit of this thesis refers to the health and well-being of those who have a uterus, as the primary focus of this thesis will be reproductive health, which is intricately connected to the possession of this organ. Male and female bodies share many similarities in their anatomy – most systems in the body, like the digestive system or the nervous system, function the same.[4] However, the differences that do exist – predominantly in the reproductive system[5] - are significant, particularly in the case of female patients. Therefore, the focus of this thesis is to analyse and understand the background regarding the discrepancies in provision, access, and cost of care which women face – in some cases daily – regarding their reproductive system.

Thirdly, the literature speaks predominantly about gender equality, meaning both men and women have equal access to care. This is a specifically Western perspective and status – in developing nations and the Global South, this equality is often far from the reality. What will be argued in this thesis, however, is that the end goal of health care policy should be gender equity by recognising that male and female bodies are constructed differently and have different biological needs – particularly concerning the reproductive system. Gender equality provides the same type and level of care for all patients. Gender equity, however, affords each patient the care that they require for *their* body – in this case, the care for a specific organ related to reproductive needs. This currently only takes place in a limited capacity, mostly to the detriment of women's health.

The thesis will draw on three main areas of theory, namely Nussbaum's philosophical work on why gender equity matters in health care, a section on Europeanization of health care is relevant to understanding the complexity of the health policy area within the European Union ('EU') and finally, theories which highlight the feminist argument concerning gender equity, the policy-making process and replication of masculine norms within this process, particularly in health care. These theories will be supplemented by a brief literature review and a separate section dedicated to understanding the intricacies of female health. This section will discuss in depth the current situation of female health, drawing on statistical data and scientific

[4] Sherwood, Lauralee. *Human physiology: from cells to systems*. Cengage learning, 2015, p.6-7.

[5] Marieb, Elaine N., and Katja Hoehn. "The reproductive system." *Human anatomy and physiology* (2003): p. 1056-1061.; Creasy, Dianne M., and Robert E. Chapin. "Male reproductive system." *Haschek and Rousseaux's handbook of Toxicologic pathology* (2013): p. 2493-2598.; Vogazianou, Artemis. "Anatomy and physiology of the female reproductive system." *Advanced Practice in Endocrinology Nursing* (2019): p.739-752.

journals. Data of this nature is vital to understanding and navigating the modern world – particularly in policymaking, and thus graphs, economic data and figures will be used to highlight the prevalence and occurrence of female health issues compared to male health issues, as well as demonstrating that female reproductive health in particular is an area of health care which is significantly underdeveloped in European health policy.

The applied section of this thesis will be composed of a comparative case study, comparing two countries which have introduced female-focussed health care policies in recent years, namely Spain and the United Kingdom ('UK'). Initially, there will be an outline of European female health data to place the two nations into context in a wider sense. Given the Brexit, the data will be taken from the Organisation for Economic Cooperation and Development ('OECD'), which includes the UK, as opposed to drawing on data provided by the EU.
At first glance, these two countries do not share many similarities, however, for the context of this thesis, they are both a strong example of progress towards gender equity for women in European health care. In the last decade, both nations have introduced policies which demonstrate an understanding of the health disadvantages faced by women by dint of their biology and have amended or addressed relevant policies in the field accordingly – both pertaining to active reproductive health care i.e., menstruation: Scotland introduced free sanitary products in public spaces, available to 'any person in need' in 2022; Spain introduced menstrual leave for those who suffer from intense pain during their menstrual cycle in early 2023. Thus, despite there being other examples across Europe and the world of similar policies and ideas taking shape, the nature of both countries being in Western Europe, the UK previously – und until relatively recently – being a member of the EU like Spain and the topic of the policies they have introduced, these two countries provide a strong basis for a comparative analysis.

Initially, both case studies will be discussed from a health statistics point of view, to understand the health needs of women in the nation. Further, the health care system will be discussed briefly, as this is the driver, tool – or obstacle – to female-focussed policy being implemented in the long-term. Understanding the system within which the policy operates is vital to its further success. Finally, the two above-mentioned policies themselves will be discussed, and additional developments in both nations on the female-health front will be discussed.
An analysis will then follow to highlight the differences in health needs, the effectiveness of the policies at meeting female health at the point of need and finally to highlight whether these policies are genuinely a (first) step in the direction of gender equity for women in health care. Where appropriate, concepts of Europeanization will be included – this is based on the case studies no longer both being EU Member states.

The analysis will conclude with recommendations drawn from the theories discussed, the case studies and the comparative analysis, to highlight key learnings as well as outline next steps which are vital to achieving the end goal of progression towards gender equity over gender equality. The purpose of these recommendations is to briefly discuss an idealistic 'roadmap' for the future of gender-equity focussed health care, focusing on the overarching steps needed to foster gender equity in health care. Much of that process relies on increased and better understanding of female health needs, which will be discussed in more detail in this section.

Theoretical Framework

In the context of this research question, there are three main theories which are relevant, namely theories on the philosophy of equality and equity, Europeanization, in the context of health care, and gender studies combined with feminist international relations ('IR') theory. Each of these theoretical frameworks will be discussed based on various sources, the below selection is an excerpt of the literature.

Why we care about gender equity

To begin, it is important to set the framework for why gender equality is important and how the lack thereof particularly affects women. Nussbaum has written several pieces[6] on the topics of justice, equality, and women. Many of her writings focus on structural and systemic disadvantages towards women and how these are portrayed differently in various areas but are all equally pertinent. In 'Human Capabilities'[7] she essentially argues that from a philosophical point of view, all human beings have ten key capabilities which define them as human and thus distinguish them from animals. She considers these capabilities to be inherent to human nature, regardless of gender, race, or religion but argues that women are often denied the recognition and acknowledgement of their own capabilities. She considers this to be partly a flaw of the systems we live in, but also driven by historical expectations and gender

[6] Nussbaum, M.C., 2000. *Women and human development: The capabilities approach* (Vol. 3). Cambridge University Press.; Nussbaum, M., 2000. *Women's capabilities and social justice*. *Journal of human development*, *1*(2). – this is a selection of her works.

[7] Martha C. Nussbaum "*Human Capabilities, Female Human Beings*", in Martha Nussbaum and Jonathan Glover, eds, Women, Culture and Development: A Study of Human Capabilities, Oxford and New York: Clarendon Press and Oxford University Press, 1995, pp. 61-104.

roles. She refers to philosophers as far as Aristotle, Plato, Rousseau, and Mills – to name a few – and argues that even at that point, women were not considered 'full' humans. In this context, she combined traditional feminist IR theory with her approaches. She describes herself as 'universalist and essentialist'[8], arguing that by nature of our belonging to the human species, we all share the same right to justice, freedom, and equality. This echoes the wording of all human rights treaties, but Nussbaum highlights discrepancies in the realisation of these theories to the detriment of women. The ten capacities which she defines are life; bodily health; bodily integrity; senses, imagination and thought, emotion; practical reason; affiliation; other species; play and control over one's environment. Nussbaum uses the capabilities approach to highlight in particular the role and position of women in her essay 'Women and equality: the capabilities approach'[9], in which she outlines in more detail the need for equality between men and women. She argues that all human beings deserve equality owing to our human dignity, which women are 'denied' consistently in varying degrees. For this thesis, the key capability which will be relevant is bodily health.

The idea of gender equity over gender equality at its core carries this notion of justice and fairness which Nussbaum discusses. Equality grants all parties fairness, whereas equity affords all parties justice. Nussbaum's argumentation along the ten capabilities supports the idea that equality in bodily health is not sufficient to meet the full human potential for women. This will be discussed in greater detail in the thesis itself, alongside further literature regarding the equity-equality debate.

Understanding health policy in the EU

Europeanization is defined in broad terms as ranging from construction, diffusion, institutionalisation and implementation of formal and informal rules, procedures, policies as well as beliefs and norms, which are created and set-out by the EU, into national policy and processes.[10] All of these elements are consolidated in EU public policy and politics which are then incorporated into domestic systems.[11] Thus, the concept of Europeanization focusses on the idea that the EU influences national public policy and domestic processes. In turn, some

[8] ibid, p. 65.

[9] Nussbaum, M., 1999. Women and equality: The capabilities approach. *Int'l Lab. Rev.*, *138*, p.227.

[10] Radaelli, C.M., 2003. The Europeanization of public policy. *The politics of Europeanization*, *320,* p.29.

[11] ibid; Börzel, T.A. and Risse, T., 2003. Conceptualizing the domestic impact of Europe. *The politics of Europeanization*, *57,* p.3.; Lenschow, A., 2006. Europeanisation of public policy. *European Union. Power and Policymaking*, *3*, pp.55-71.

authors argue that this process is a two-way street, namely that individual nations - and even individual actors - can shape and change what is considered 'European'. Thus, the past five decades of public policy in the European area have been influenced by the EU – that much is clear.[12] Others argue[13] that amid of this process taking place individuals, even those without formal decision-making power, can influence the outputs of such discussions at the EU level. There has been an upsurge in interest in Europeanization on an academic level in the past 15 to 20 years,[14] given that it is suspected that Europeanization is doing more than 'only' influencing policy. It is thought to also be affecting the implementation of EU decisions and regulations at the national level. If this were the case, this could – in the long-term – render the EU ineffective, as its directives, regulations and informal guidelines may no longer be adhered to in their full extent. Therefore, Europeanization is a process of generating power and maintaining it. To understand this power dynamic effectively, it is key to understand the power of the individual actors, the member states and the links between policies and values.

In the context of health care, this process is particularly complex in the EU. Member states historically try to retain control over their domestic health care systems and policies, given that it is a strong source of electoral capital and influence in their national context. Therefore, thus far health policy has been considered relatively untouched by Europeanization.[15] However, scholars recognise that the Commission has increased interest in further integration in this field. According to the treaties governing the EU, the organisation and delivery of public health care remain within the sole authority of the member states.[16] Equally, all input into the health care system, such as staff, materials, supplies and medications, all enjoy market freedoms and regulatory processes which are subject to integration processes within the EU, which are argued to be part of Europeanization.[17] All member states have some form of public health care system, and much of the organisation and allocation of the services within that system remain under national jurisdiction and organisation. However, the allocation of the resources within that system is often politically driven, or at the least influenced, thus making this process susceptible to Europeanization. The biggest challenge to Europeanization in this area specifically is the vast differences between member states health care systems and policy

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[12] Radaelli, C.M. and Saurugger, S., 2008. The Europeanization of public policies: Introduction. *Journal of Comparative Policy Analysis: Research and Practice*, *10*(3), pp.213-219.

[13] ibid

[14] Exadaktylos, T. and Radaelli, C.M., 2009. Research design in European studies: the case of Europeanization. *JCMS: Journal of Common Market Studies*, *47*(3), pp.507-530.

[15] Böhm, K., & Landwehr, C. (2014). The Europeanization of health care coverage decisions: EU-regulation, policy learning and cooperation in decision-making. *Journal of European Integration*, *36*(1), p.17-35.

[16] Art. 168 No. 7 TFEU, formerly Art. 152 (5) TEC

[17] supra [12]

processes.[18] This covers the structure, financial and societal areas of the public health system, thus making it particularly complex.

For this thesis, Europeanization is important on two counts: firstly, despite the challenges to Europeanization in the health care sector, there remain key regulations which are driven by the EU that are implemented and relevant to both countries within the case study. This is relevant despite Brexit, as in the historical context of Europeanization and the EU, Brexit is recent history. Secondly, one cannot assume that purely because Europeanization is challenging, it is not a goal the EU is striving for in the health care sector – particularly in the aftermath of the COVID-19 pandemic. Thus, analysing and understanding Europeanization as a concept will aid the understanding of the case study countries, as well as highlighting whether the Europeanization of this sector could be beneficial to working towards gender equity in health care or not.

Why equity in female health matters most

Europeanization and integration theories focus significantly on the idea of power and how power is gained and maintained within the EU construct. A further element of this power is the role of gender in power dynamics. Kronsell speaks about this, making it a vital addition to the theoretical framework of the thesis, alongside traditional feminist IR theories.

Kronsell[19] argues that integration theory does not question the masculine norms of power which are present in the EU. There is a significant amount of research regarding gender equality in EU studies and textbooks, but much of it focuses on gender equality in terms of working conditions and care responsibilities (childcare related). Kronsell herself states that feminist theory provides a helpful tool to address the masculine underpinnings of power. She argues that, despite the scholarship that does exist regarding gender equality, and that it is mostly related to women, i.e., gender = woman, the understanding of gender as a power relation is only implicitly discussed, if it is recognised at all. Kantola – a further scholar in the area, assessed that feminism is a critical voice in the process of evaluating the success of integrating gender effectively into the EU agenda.[20] Therefore, despite the portrayed

[18] supra [12]

[19] Kronsell, A. (2016). The power of EU masculinities: A feminist contribution to European integration theory. *JCMS: journal of common market studies*, *54*(1), p.104-120.

[20] Kantola, J., 2010. *Gender and the European Union*. Bloomsbury Publishing. p.167.

understanding of gender or the addition of gender studies to the EU agenda and policy process, Kronsell and Kantola argue that the focus of these areas lies exclusively on women in traditional roles, explained as the role of women in parenting and caregiving. They argue that this pushes women further to the fringes of policy areas and policymaking and does not enable their integration as it originally sought to.

Feminist theory,[21] to simplify and conglomerate, seeks to eradicate exactly these perceived 'gender roles' in the interest of generating a more equal society. There are different streams of feminism which have different focuses, which will be discussed in the thesis. In the context of gender theories in the EU and how it relates to EU policy, it is key to recognise the hierarchies of gender rooted in the political practices and the structure of the institutions. The 'gender gap' goes further than only the output (policy) from the institutions; the authors argue that it is engrained into the fabric of its operations (policymaking).

Women have historically faced inequality in almost every social, societal, and political process and system.[22] The health care system is no exception. In the Westernised context, equality of access to health care facilities and treatments has been met in many ways – and yet, health care-related research and development is frequently based on male study subjects alone[23]; the majority of women experience regular health-related challenges by dint of their biology which remain poorly understood or treatments carry significant side-effects[24]; the majority of costs for necessary sanitary products or pain medication are carried by women themselves

[21] MacKinnon, C.A., 1987. *Feminism unmodified: Discourses on life and law*. Harvard University Press.; MacKinnon, C.A., 1989. Toward a feminist theory of the state. Harvard University Press.; Gross, E., 2013. Conclusion: What is feminist theory? In *Feminist challenges* (pp. 190-204). Routledge. – examples of scholarship in the area referenced in their totality in this thesis.

[22] Carter, P.L. and Reardon, S.F., 2014. *Inequality matters*. New York, NY: William T. Grant Foundation.; Ford, Lynne E. *Women and politics: The pursuit of equality*. Routledge, 2018.

[23] Bird, Chloe E. "Women's representation as subjects in clinical studies: a pilot study of research published in JAMA in 1990 and 1992." *Women and health research: Ethical and legal issues of including women in clinical studies* 2 (1994): p.151-173.; supra [2]; Roche International, Data is everything: the importance of closing the gender data gap, author unknown, published on 4 November 2022, accessed at https://www.roche.com/xproject/xstories/gender-data-bias/ on 15 January 2023.

[24] Azziz, Ricardo. "PCOS: a diagnostic challenge." *Reproductive biomedicine online* 8, no. 6 (2004): p. 644-648.; Carmina, Enrico, and Rogerio A. Lobo. "Polycystic ovary syndrome (PCOS): arguably the most common endocrinopathy is associated with significant morbidity in women." *The journal of clinical endocrinology & metabolism,* 84, no. 6 (1999): p.1897-1899.; Arbyn, M., Weiderpass, E., Bruni, L., de Sanjosé, S., Saraiya, M., Ferlay, J. and Bray, F., 2020. Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis. *The Lancet Global Health*, *8*(2), pp.191-203.; Schwartz, Kaia, Natalia C. Llarena, Jenna M. Rehmer, Elliott G. Richards, and Tommaso Falcone. "The role of pharmacotherapy in the treatment of endometriosis across the lifespan." *Expert opinion on pharmacotherapy* 21, no. 8 (2020): p.893-903.

and have in the past been taxed as 'luxury items'[25] – access to these necessary items is not possible for all women due to the cost. Recognising that male and female needs in health care, both physical and mental, differ and that health care policies must reflect these differences to provide truly effective health care is the first step towards gaining gender equity.

For this thesis, these theories bring the feminist argument into the conversation about gender equity, the policy-shaping process and reproduction of masculine norms within the system – health care is included in this process. Alongside the writings of Nussbaum, these theories will enhance the understanding of the 'problem' with gender equality and the need for gender equity.

The three theoretical frameworks chosen are varied across different types of writing and academia, but all contribute valuable insights into the key areas which are necessary to understand the research question and the topic at hand. The theories and the abovementioned authors have been chosen specifically for these sections as they give a strong overview of the subject matter, which is helpful at an early stage of research. However, there are some weaknesses to the chosen literature which require consideration going forward, but equally, provide the opportunity to fill a gap in the literature.

In the case of Nussbaum, her writing is instrumental to understanding more broadly the position of women in the political system by dint of their nature, their belonging to the human species. The philosophical angle strengthens the moral argumentation behind striving for equity as opposed to settling for equality. A weakness here is that she does not directly speak about equity, but she focusses on equality, thus, this section of the thesis would need to be supplemented with additional research on this equality-equity paradigm.

Considering the writings chosen on Europeanization, the academic research on this phenomenon is relatively recent as a discipline, meaning there is a lack of historical data. This is not so much a weakness, but more a disadvantage to understanding the historical development of the position of women and how Europeanization may have had an effect. Further, much of the writing is descriptive, research-based, and analytical, rather than discussing the benefits, drawbacks and tangible impact which Europeanization is having. This portion of the research for the thesis would be particularly enhanced by a discussion regarding

[25] Hunter, Lea. "The 'Tampon Tax': Public Discourse of Policies Concerning Menstrual Taboo." *Hinckley J Politics* 17 (2016): p.11-18.; Finley, Kitana, Tatiana Crawl, and Marie Bazile. "Should Feminine Products be Taxed as a Luxury?" (2019).

the actual impact of Europeanization and whether this could yield benefits – or drawbacks – for women in the provision of their health care.

The complexity of Female Health

Empirical Framework

"We […] know less about every aspect of female biology compared to male biology"[26]

Maintaining the health of individuals as well as society has in many ways moved the forefront of political debate and social discourse[27] – from lecture halls to social media content. Not only on a theoretical level, but in practical terms, health has a vital role to play in government and politics.[28] In 2015, the United Nations ('UN') recognised gender equity in health care as one of the Sustainable Development Goals.[29] In 2020, the expenditure for health care-related services across the EU came to 15,1% of the total expenditure of the institution.[30] Thus, the health care industry is a significant contributor to society, but also in terms of expense – this applies on the national level as well as on the international scale.[31]

However, health care policy, owing to the nature of the object it serves - which is people's health - is significantly more complex than a game of numbers or a percentage on a spreadsheet. Health care policy carries the weight of providing citizens with the services and technology they require to live, thrive and in some cases survive. This burden applies to all human beings – and yet, the distribution and the level of need differs according to individuals, differs within nations, states, and regions. Health – or the lack thereof – is not quantifiable or

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[26] New York Times, 'Health Researchers Will Get $10.1 Million to Counter Gender Bias in Studies', Dr. Janine Austin Clayton, published 23 September 2014, accessed at https://www.nytimes.com/2014/09/23/health/23gender.html on 23 February 2023.

[27] Sagan, Anna, Erin Webb, Natasha Azzopardi-Muscat, Isabel de la Mata, Martin McKee, and Josep Figueras. *Health systems resilience during COVID-19: Lessons for building back better*. World Health Organisation. Regional Office for Europe, 2021.; Søvold, Lene E., John A. Naslund, Antonis A. Kousoulis, Shekhar Saxena, M. Walid Qoronfleh, Christoffel Grobler, and Lars Münter. "Prioritizing the mental health and well-being of health care workers: an urgent global public health priority." *Frontiers in public health* 9 (2021): 679397.

[28] Kruk, Margaret E., Anna D. Gage, Catherine Arsenault, Keely Jordan, Hannah H. Leslie, Sanam Roder-DeWan, Olusoji Adeyi et al. "High-quality health systems in the Sustainable Development Goals era: time for a revolution." *The Lancet global health* 6, no. 11 (2018): p.1196-1252.

[29] United Nations, UN Sustainable Development Goals Fund, Goal 3 "Good Health and Well-being", accessed at: https://jointsdgfund.org/sustainable-development-goals/goal-3-good-health-and-well-being on 25 February 2023.

[30] Eurostat, 'Government expenditure on health', published on 18 November 2022, accessed at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Government_expenditure_on_health on 4 March 2023.; World Health Organisation, 'Global Health Expenditure database', accessed at apps.who.int/nha/database on 4 March 2023.

[31] OECD European Union. *Health at a glance: Europe 2018 state of health in the EU cycle*. OECD, 2018.

unilateral across populations. However, one element that is as close as unilaterally applicable to a people group is female reproductive health in female patients.

Health is intricately related to gender – particularly for women. 'Women's health' is a broad term which refers to physical and mental health problems that exclusively concern women, and which are more common in women or differ in presentation, severity, or consequences in women compared to men.[32] In some cases, by dint of biology, they are exclusively women-related, such as all things concerning the female reproductive system.

According to the Constitution of the World Health Organisation ('WHO'), health is defined as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. Such a definition is particularly important to reproductive health for women.[33] This understanding of health in the context of reproductive health does not only require women and their reproductive processes to be free from disease or disorders, but a state of *complete* physical, mental, and social well-being. This has been understood to encompass the capacity for fertility, health and sustainable pregnancy, and informed sexual relations free from danger or risk to health.[34]

Thus, health per se is significantly more complex than merely being the opposite of 'unwell'. In the context of female reproductive health, given the frequency, duration and regularity of menstruation and its side-effects, also exacerbated the incurring disorders, should render this one of the biggest areas of policy, research and development and medicinal support. And yet, millions of women live without education, without treatment or without appropriate care – in the developing world even more so than elsewhere.

General overview of female health issues

Current data demonstrates that women form 51,2% of the European Community (EC) population – totalling 191 million individuals. Across member states, this statistic remains stable, the most noted variance in this aspect is in terms of age: there are more women who are older than there are younger women, increased by the fact that women have longer life expectancy than men. To understand women's health, there are two important factors to

[32] M.N. Haan, Women's Health, International Encyclopedia of the Social & Behavioural Sciences, Pergamon, 2001, p.16528-16532.

[33] M.F. Fathalla, Issues in Reproductive Health, *Health and being a woman*, United Nations Women Watch, 1988.

[34] ibid

consider, which outline why in particular female health is complex and where there are unmet needs in the political, legal, and societal processes. These are on the one hand the uniqueness of the female reproductive system and on the other the societal role of women and how this impacts their health opportunities. These will be discussed individually and underlined by statistic evidence to highlight where the gaps lie in female health needs. Concerning female health, there will be a brief overview of female health statistics pertaining to health-related issues that are gender-specific or gender-exacerbated before focusing on female reproductive health. However, there are also legal and political factors are relevant to the discussion of inequality which women face, thus, an explicit section will be dedicated to these topics. Given the ambit of this thesis and the case study nations, the focus is on the European continental area. Where a specific area is used for statistical analysis e.g., the EC or the EU, this will be specified.

Female-specific health threats

The two main sources of death in women are diseases of the circulatory and cardiovascular system, equating to 43% of all deaths across the European Economic Community ('EEC'), and cancer, which equates to 26% of deaths. Deaths in these two areas are often – if based on illness – avoidable. If detected early and treated appropriately many cancers, heart attacks, strokes or similar circulatory system illnesses do not carry dire consequences. Specifically female cancers, such as breast and cervical cancer, are considered the main cause of death for women between 35-64 years of age in the EEC, despite both being well-treatable if recognised in the early stages. Circulatory and cardiovascular related deaths are more common in the older age brackets.

A further illness which many women struggle with and has a noted female contingent to it is osteoporosis, which if detected early in bone density scans can be managed and prevented from getting to particularly bad stages. However, such scans need to be done regularly starting at a certain age. A recent statistic highlights that in the EEC only 16% of women had an osteoporosis test in the last year, which given the rapidly ageing population is a concerning value. However, roughly 40% reported having had a cervical smear test in the last year. Only 16% of women reported having had a mammography in the past year as a preventative test for breast cancer. One of the most prevalent diseases in women are cardiovascular diseases[35] – they are also one of the leading causes of death in women.

[35] supra [32]

Women's health is often analysed in narrow terms by focusing on a specific organ or body part i.e., the uterus or digestive system, as opposed to studying symptoms and illnesses through a sex-specific lens. Until as late as 1993, women were excluded from clinical research and trials in the European area.[36] Despite a vast improvement in this area, women are still often underrepresented in various aspects of clinical research processes, and even when women are included, the data is not necessarily analysed according to sex,[37] posing a further disadvantage.

Health care systems rely on statistical and demographic data to make informed decisions. The issue herewith is that oftentimes the data being used is shaped by and based on male subjects, and often male subjects exclusively.[38] It was only in 2019 that the WHO's Global Health Statistics were disaggregated by sex for the first time.[39] In 2016, a clinical trial for a female version of Viagra was tested using an almost entirely male cohort (92%).[40] Research has indicated that medicinal and pharmaceutical products are safer – and more effective – when the clinical trial relies on a diverse pool of subjects – and yet women are routinely underrepresented in such trials.[41] A pan-European review of such trials for cardiovascular diseases highlighted that on average less than 35% of subjects are women and that fewer trials report results on the basis of sex.[42]

Uniqueness of the female reproductive system

The reproductive system serves as the clearest example of discrepancies in access and provision of health care between males and females, as it contributes to the biggest

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[36] Mauvais-Jarvis, F., Merz, N.B., Barnes, P.J., Brinton, R.D., Carrero, J.J., DeMeo, D.L., De Vries, G.J., Epperson, C.N., Govindan, R., Klein, S.L. and Lonardo, A., 2020. Sex and gender: modifiers of health, disease, and medicine. *The Lancet*, *396*(10250), pp.565-582.

[37] Woitowich, N.C., Beery, A. and Woodruff, T., 2020. A 10-year follow-up study of sex inclusion in the biological sciences. *Elife*, *9*, p.56344.

[38] supra [23]

[39] World health Statistics 2022: Monitoring Health for the SDGs, Sustainable Development Goals. Geneva: World Health Organisation; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[40] Yale School of Medicine, 'A Drug for Women, Tested on Men', authored by Carissa Violante, published on 14 January 2016, accessed at https://medicine.yale.edu/news-article/a-drug-for-women-tested-on-men/ on 15 March 2023.

[41] Kim AM, Tingen CM, Woodruff TK. Sex bias in trials and treatment must end. Nature 2010:465(7299):p.688–9.; Kaplan W, Wirtz WJ, Mantel-Teeuwisse A, Stolk P, Duthey B, Laing R. Priority medicines for Europe and the world 2013 update. Geneva: World Health Organisation (2013) (http://www.who.int/medicines/areas/priority_medicines/MasterDocJune28_FINAL_Web.pdf accessed 16 March 2023.

[42] Stramba-Badiale M. Women and research on cardiovascular diseases in Europe: a report from the European heart health strategy (EUROHEART), 2010;31:p.1677–81.

differences in medical needs.[43] This can be understood as two separate challenges: active and passive care. Active care means access to sanitary products and pain medication during menstruation, regular gynaecological visits and similar; passive care refers to preventative health care in the form of regular check-ups which are intended to prevent the development of severe gender-specific illnesses at later stages in life. Examples of this type of health care for females are regular scans for breast cancer and osteoporosis, regular PAP smears and STI checks. These regular checks begin as early as 13 years of age and become more frequent in later years.[44] For males, the main form of preventative medical care is regular prostate examinations which typically start around 55 years of age.[45] The reproductive differences alone provide sufficient evidence that a gender-specific approach holds potential for improvement.

The heightened need for medical attention in female reproductive care has two reasons: firstly, all women menstruate – aside from a small percentage that have illnesses, malfunctions or do not have a uterus. Secondly, typically menstruation takes place regularly on a monthly basis for a significant proportion of a woman's life. On average, a woman will spend 10 years of her life menstruating; it is estimated that at any given moment, roughly 26% of the global population is menstruating.[46] This is the same across geography and socioeconomic class, making it a universal female issue.[47] Across Europe, a self-assessed health review was conducted in 17 countries. The review found that levels varied significantly between countries, but that women had consistently worse self-reported health than men. The cause for this is unknown, but some sources state that this is merely an indicator of women's greater burden of disease. Such a mindset indicates acceptance of the fact that women live in poorer health, as nothing in biology, anatomy or scientific evidence would suggest that female bodies are presupposed for poor health.[48]

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[43] supra [6]

[44] Bryan, Ava F., and Julie Chor. "Factors influencing adolescent and young adults' first pelvic examination experiences: A qualitative study." *Journal of paediatric and adolescent gynaecology* 32, no. 3 (2019): p. 278-283.

[45] Prostate Cancer: Age-Specific Screening Guidelines by Christian Paul Pavlovich, M.D., Hopkins Medicine, https://www.hopkinsmedicine.org/health/conditions-and-diseases/prostate-cancer/prostate-cancer-age-specific-screening-guidelines accessed 28 December 2022.

[46] The Borgen Project, 'Menstruation, Education and Poverty' by Elizabeth Reece Baker, published on 10 February 2020, accessed at https://borgenproject.org/menstruation-education-and-poverty/ on 18 February 2023.

[47] ibid

[48] Dahlin J, Härkönen J. Cross-national differences in the gender gap in subjective health in Europe: does country-level gender equality matter? Soc Sci Med. 2013;98: p.24–8.

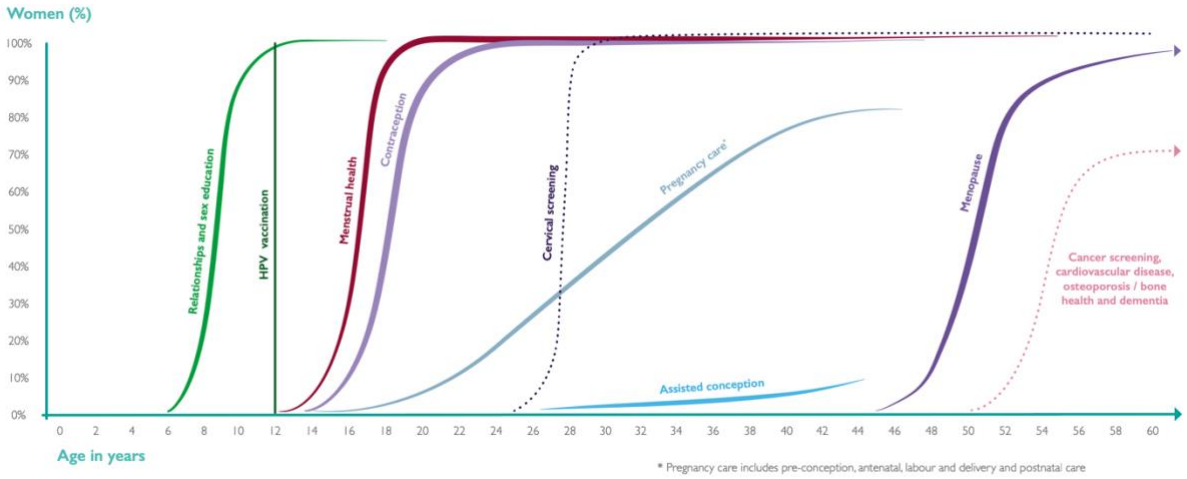

Figure 2: Stages of female reproductive development and health factors

Women have unique health requirements relating to their reproductive system – this encompasses the ovaries, fallopian tubes, uterus, vagina, accessory glands, and external genital organs.[49] This system, as highlighted in Figure 1, is highly complex and intricately connected to other processes in the female body, which can impact disease patterns and illness progression. A significantly contributor to this is the uniquely delicate balance of female hormones. This is relevant to both the active phase, in which menstruation takes place, as well as the in-active phase before menstruation and after menopause. The female health care system is also prone to complications and illnesses – in tandem with the regularity and frequency of menstruation and pregnancy, this renders female reproductive health needs one of the most wide-spread and urgent health care needs across the globe.

A significant challenge to gender equity in health care is the limited understanding of female health in medical practice, pharmaceutical research, and development and – partially – female anatomy and biological processes. As with men, health care for women can be divided into active health care and preventative health care, which involves screening for female-specific cancers and diseases. In lieu of the reproductive system of women, there are significantly more aspects in female health care to consider than for men. For example, the capacity to bear children brings with it an onslaught of symptoms, potential risks, and an additional organ. Thus, female health care covers the areas[50] of birth control, STIs, gynaecology, cancers of

[49] National Cancer Institute, SEER Training Modules, 'Female Reproductive System', author unknown, accessed at https://training.seer.cancer.gov/anatomy/reproductive/female/ on 18 February 2023.

[50] Mendiratta V, Lentz GM. History, physical examination, and preventive health care. In: Gershenson DM, Lentz GM, Valea FA, Lobo RA, eds. *Comprehensive Gynaecology*. 8th ed. Philadelphia, PA: Elsevier; 2022: Chapter 7.

the breast, ovaries and cervix and all corresponding treatments and screenings, menopause and hormone therapy, osteoporosis checks, benign conditions of the female reproductive organs, such as endometriosis, PCOS, PMDD and PMS,[51] heart disease and pregnancy and childbirth.[52] This is a non-exhaustive list of health care needs which exclusively[53] relate to women. The list is seemingly endless, and the needs are multifaceted. Often health care problems are interrelated and comorbid, but this is especially relevant in female reproductive health, given the nature of the 28-day hormonal cycle and the complexity and lack of research into this cycle and its effect and impact on other biological systems and processes.

Female health needs are shaped by their biology mostly, but these are also impacted by gender roles and social interactions, such as work-life balance and child rearing. These factors are differential across the individuals' lifespan, making it particularly relevant to women's reproductive health. However, female health must consider female health as a whole, whereas it is very frequently discussed directly in tandem – or exclusively in the context of maternal health, despite the two not being mutually inclusive. Thus, not only policy, but also legal frameworks are important to factor into the discussion about female health.

Women in society & incurring health impacts

Despite menstruation being a consistent and constant process, there are vast discrepancies in geographical and socioeconomic terms. Being a woman in a developed, Westernized country, one is significantly 'better off' than in a developing nation – this refers to the care available, the medication, the understanding of poor reproductive health and maternal health, differences in stigma and discrimination towards women in certain regions, and the economic burden of sanitary products needed for this biological process. Thus, there is work to be done to improve female reproductive health in every country, but the developed world is several steps ahead in this regard. Experiences such as female genital mutilation, sexual assault and domestic violence are factors which significantly affect women's health and are statistically significantly more prevalent – some even exclusively - problems for women than men. Thus, considering the role of women in society, such practices and experiences are essential to the discussion of female health. Such issues are more common in developing nations, and thus

[51] Gambone JC. Menstrual cycle-influenced disorders. In: Hacker NF, Gambone JC, Hobel CJ, eds. *Hacker & Moore's Essentials of Obstetrics and Gynaecology*. 6th ed. Philadelphia, PA: Elsevier; 2016: Chapter 36.

[52] Freund KM. Approach to women's health. In: Goldman L, Schafer AI, eds. *Goldman-Cecil Medicine*. 26th ed. Philadelphia, PA: Elsevier; 2020: Chapter 224.

[53] Heart disease, osteoporosis, STIs are also relevant to men, but women suffer of these illnesses more than men.

out of the ambit of this thesis, but it is important to highlight this in the context of inequality of women in society.

The Minsk Declaration recognised that health systems benefit from considering life as a continuum: a spectrum of beginning to end of life which carries with it a variety of health factors and likelihood of illnesses. This holistic approach considers the concepts of health and well-being across different stages and relevant risk factors of each stage. For women's health, the reproductive years are particularly key in this regard, as this is when the predominance of regular and consistent health issues arise. Further, research has indicated that women's health is often intricately connected to children's health and well-being, thus, women's health is not only multifaceted but also in many ways intergenerational. To return to the above statistic of 51.2% of the EC population being women – if the percentage of children in the population is added,[54] the percentage of the population that is more likely to live in poor health is everybody except men - equating to an astonishing 67%.

Expanding from this, one argument that the review brought to light is that family policy has a significant impact on female health, by either exacerbating its negative effect by creating conflict between family-life balance or encouraging a healthy dynamic between the two. It was reported that women in southern and central Europe and more contradictory family policy models are likely to report poorer health than men. In the context of the case studies, it is important to highlight that despite the differences in culture between the UK and Spain, both countries have a similar gender gap index. It is argued that such policy and its detrimental effect equates to neutral indirect discrimination, based on allegedly neutral legal standards or policies nor providing care that is genuinely adapted to women and their health needs. Rather, the health care system often provides care based on a male-dominated standard and therefore does not effectively address women's health needs.

Sexual and reproductive health and rights

Multiple human rights, such as the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination, are connected to women's sexual and reproductive health. Women's right to health encompasses their sexual and reproductive health, according to the Committee on Economic, Social, and Cultural Rights ('CESCR') and the Committee on the Elimination of Discrimination Against

[54] The Global Economy, Percent of children – country rankings, author unknown, sourced by United Nations Population Division, accessed at https://www.theglobaleconomy.com/rankings/percent_children/Europe/ on 19 February 2023.

Women ('CEDAW'), respectively. States have the obligation to respect, protect and fulfil rights related to women's sexual and reproductive health. According to the Special Rapporteur on the right to health, women are entitled to reproductive health care services, and goods and facilities that should be available in adequate numbers; accessible physically and economically; accessible without discrimination; and of good quality.[55]

Despite the protection of these rights under CEDAW, there are several universally recognised violations, such as denial of access to services that only women require; poor quality services; subjecting women's access to services to third party authorisation; forced sterilisation, forced virginity examination, and forced abortion, without women's prior consent; female genital mutilation (FGM); and early marriage.[56] Particularly relevant in this context are the issues of denial of access to service and particularly poor quality services.

Thus, collectively across these two areas, it is clear that female health is important, given the percentage of the population it affects – as well as the follow-on effects poor female health has in the wider ambit of family and community life. In addition, the lack of research into female health needs – particularly of the reproductive system – exacerbate these negative effects. All of this combined with the lack of support for policy approaches which remedy this and the lack of respect for sexual and reproductive health rights for women, highlights why female reproductive health is not merely a part of health policy, but should be a significantly more important factor in policy decisions and health care system creations. In 2011, the WHO already spoke about 'gender-transformative actions and policies' as policies which address the causes of gender-based health inequalities,[57] highlighting that gender-specific care considers in greater detail the specific needs of men and women's physical needs.

The goal of such policies is to promote gender equality and foster progressive changes for the benefit of women who have suffered unequal treatment for decades – if not since the beginning of Ancient politics.[58] The idea of a gender-based approach means supporting the

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[55] Hunt, P., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, United Nations General Assembly, 61st Session (13 September 2009) accessed at https://ap.ohchr.org/documents/dpage_e.aspx?si=A/61/338 on 22 February 2023.

[56] United Nations, Office of the High Commissioner for Human Rights, *Sexual and reproductive health and rights, OHCHR and women's human rights and gender equality*, publication date unknown, author unspecified, accessed at https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights on 22 February 2023.

[57] World Health Organisation, Gender mainstreaming for health managers: a practical approach. Geneva. (2011) (http://www.who.int/gender-equity-rights/knowledge/health_managers_guide/en), accessed 16 April 2023.

[58] supra [2]

need to strengthen the understanding of the determinants of men's as well as women's health with a view to making policies and strategies more responsive to both men's and women's needs across the life-course.[59] As part of the 2030 Agenda for Sustainable Development Goals,[60] most member states have agreed to strive for gender equality in health and well-being.

In economic terms, European expenditure in the health sector has risen incrementally and consistently in the past 20 years – oftentimes this is consistent over all measures i.e., whether the expenditure is proportional to GDP, to per capita or a noted general increase.[61] Despite a period of poor or even negative growth in health spending across Europe following the 2008 financial crisis, growth rates have increased in almost all nations. Between 2013 and 2019, health spending per person in EU countries increased on average by over 3.0% per year in real terms (adjusted for inflation), compared to an annual growth rate of approximately 0.7% between 2008 and 2013. Health spending increased in all EU nations; however, this growth varies.[62]

Having outlined the main challenges in female health and the policy development in the European area, it is important to exemplify two countries which are providing positive examples of actively seeking to change the narrative of male-dominated health, namely the UK and Spain. Primarily, both countries will be analysed individually by discussing the national female health statistics, then their health care systems and finally focussing on the concrete policy examples where women and their health needs have been placed in the forefront.
The policies will be analysed from a political and economic standpoint, highlighting the political parties involved in the development and implementation of the policy and further the societal and economic impact of these policies. To preface the context of these two nations, a brief overview of European health systems will be provided. Subsequently, a discussion will bring the two policies together to highlight whether these policies are achieving the desired effect of moving towards gender equity in health care as a long-term goal.

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[59] World Health Organisation, *Strategy on women's health and well-being in the WHO European Region.* (2016) (https://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf), accessed 16 April 2023.

[60] ibid, SDGs 3, 5 and 10.

[61] World Health Organisation, *Domestic general government health expenditure (% of GDP) - European Union*: *Global Health Expenditure database* (apps.who.int/nha/database). The data was retrieved by the World Bank on April 7, 2023; accessed at https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=EU on 17 April 2023.

[62] Health at a Glance: Europe 2020: State of Health in the EU Cycle, Health expenditure per capita: OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris.

Paving the way for gender equity

Case Studies & Comparative Analysis

Case study 1: The United Kingdom

For the purposes of this case study, the term 'United Kingdom' will be discussed according to individual nations, as opposed to a whole, predominantly focussing on England and Scotland. The three main examples of female-focussed health policy in the UK are regionalised in Scotland and England. Wales and Northern Ireland will not specifically be discussed within the ambit of this thesis, as there is little to no development in female-focussed health care in these regions.

Primarily, to understand the context of the policies in question, it is key to understand what female health looks like in the UK. Subsequently, understanding the health care system is vital to understanding the context of the policies. The system not only influences, but also dictates how policy can be implemented, thus, understanding the system is paramount. Finally, the three policies will be outlined in detail.

National female health

"For generations, women have lived with a health and care system that is mostly designed by men, for men. " [63] – Matt Hancock, Former Secretary of State for Health and Social Care

The average woman in the UK spends a quarter or her life in poor health, compared to a fifth for men.[64] This gender gap is further exacerbated by socioeconomic differences and race, making health not only inequal but exacerbated by intersectional complexity. On average, UK

[63] UK Government, *Women's Health Strategy: Call for Evidence, Ministerial Foreword*. Department of Health & Social Care (13 April 2022), accessed at https://www.gov.uk/government/consultations/womens-health-strategy-call-for-evidence/womens-health-strategy-call-for-evidence#the-womens-health-strategy on 28 March 2023.

[64] High Speed Training, ‚What are Gender Health Inequalities?' by Victoria O'Regan , published on 23 September 2022, accessed at https://www.highspeedtraining.co.uk/hub/gender-health-inequalities/ on 28 March 2023.; The Independent, ‚Women spend more years of their life in poor health than men, major new report finds' by Chloe Farand, published on 18 July 2017, accessed at https://www.independent.co.uk/news/health/womens-health-compared-men-poor-condition-life-new-report-public-health-england-a7840016.html on 28 March 2023.

women live longer than men, by roughly four years – some reports even stating up to 8 years[65] - but according to research, this longer life is spent in poorer health. Women are living an estimated 19.1 years in poor health, equating to 23% of their lives, whereas for men the average lies at 16 years for 23% of their lives. In 2021, the leading cause of death for females was dementia and Alzheimer's disease (40,250 deaths; 14.0% of all female deaths).[66] Female life expectancy in the UK has risen slower than male life expectancy since the 1980s[67] - and registered a stagnation of growth since the global financial crisis in 2008. The UK has showed one of the worst trends in the European area regarding improvement of life expectancy – for women no improvement at all, for men an improvement of 0.8%.[68] Also, there are racial disparities in the health between women in England and Wales, where women from more than half of the ethnic minorities for whom statistics are available (9 out of 16 ethnic minorities) had lower life expectancy at birth than White British (64.1 years), particularly among Black, Asian, and mixed ethnic groups. The lowest life expectancy was recorded by Pakistani women (55.1 years), while Indian women had a life expectancy comparable to that of White British women.[69]

Women also bear the brunt of reproductive ill health due to the nature of their biology and the female anatomy.[70] This is intensified by social, economic and political disadvantages and is particularly common in terms of menstrual health, such as overlooking potential causes for pain, or not considering symptoms as relevant to menopause.[71] According to a study by Manual, the UK has the largest female health gap among the G20 countries and the 12th largest globally.[72] Women are underrepresented in clinical trials, medical research is granted

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[65] The Kings Fund, ‚*Reducing women's health inequalities in the most-deprived areas*', author unknown, published on 29 June 2022, accessed at https://www.kingsfund.org.uk/events/reducing-womens-health-inequalities-most-deprived-areas on 28 March 2023.

[66] Office for National Statistics (UK), *Deaths registered in England and Wales: 2021* (1 July 2022), authored by Fred Barton and Alexander Cooke, accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2021 on 28 March 2023.

[67] UK Government Press Release, *'Government launches call for evidence to improve health and well-being of women in England*' by Department of Health and Social Care (6 March 2021), accessed at https://www.gov.uk/government/news/government-launches-call-for-evidence-to-improve-health-and-wellbeing-of-women-in-england on 28 March 2023.

[68] British Medical Association, '*Health inequalities and women – addressing unmet needs*' by Dr. Jessica Allen and Dr. Flavia Sesti, published August 2018, accessed at https://www.bma.org.uk/media/2116/bma-womens-health-inequalities-report-aug-2018.pdf on 28 March 2023.

[69] ibid

[70] British Medical Association, ‚*Reproductive health and wellbeing: addressing unmet needs*' by Dr. Sue Mann and Prof. Judith Stephenson, published August 2018, accessed at https://bit.ly/2QPGQh2 on 28 March 2023.

[71] supra [64]

[72] *Manual, 'The men's health gap*' by Dr. Earim Chaudry, publishing date unknown (data includes COVID-19 parameters, thus recent publication) accessed at https://www.manual.co/mens-health-gap/ on 29 March 2023.

less funding if proposed by a woman and so on.[73] Such systemic discrimination against women leaves them chronically misunderstood, mistreated and misdiagnosed.[74] Women are also frequently misdiagnosed when suffering a heart-attack, as the typical 'male' symptoms are not the tell-tale signs for women – this is thought to be due to lack of female representation in clinical trials and lack of research into female health issues. Not just are women typically diagnosed later and with less accuracy, but there is also significantly less research and knowledge about specifically female-health issues. A prime example of this problem is endometriosis, which carries an average of 7 to 8 years waiting period for a woman to receive a diagnosis in the UK. It is estimated that 40% of women require 10 or more GP visits before being referred to a specialist.[75] For women of colour, this average is even worse, highlighting that 50% are less likely to be diagnosed with endometriosis in the first place.[76] In a similar vein, many of the issues that besiege women every month, like heavy menstrual bleeding and associated pain, are overlooked. In addition to that, in later life when menopause or pregnancy becomes a topic of discussion, this takes a toll on workforce participation, productivity and labour market potential for women specifically. A study by the University of Leeds highlighted that – despite women making up 51% of the population – women with coronary artery blockage were 59% more likely to be misdiagnosed than men, thus, suffering double the likelihood of death by a heart attack.[77] Not because the heart attack is more severe, but because it remains untreated.

A government-led survey from 2018, entitled 'Public Health England' highlighted that only half of the women suffering from menstrual problems seek help.[78] The report shows the extent of the impact such issues have on women, their ability to work and to go about daily business. It also forms the basis of a cross-governmental 5-year action plan on reproductive health. This is one of the key policies which be analysed at a later stage. The survey indicated that 31% of women suffered from severe reproductive health symptoms over the past year, including

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[73] Y. Wang, K. Hunt, I. Nazareth, N. Freemantle, I. Petersen (2013) Do men consult less than women? An analysis of routinely collected UK general practice data (https://bit.ly/3natls9)

[74] supra [2]

[75] supra [67]

[76] Mousa, M., Al-Jefout, M., Alsafar, H., Becker, C.M., Zondervan, K.T. and Rahmioglu, N., 2021. Impact of endometriosis in women of Arab ancestry on health-related quality of life, work productivity, and diagnostic delay. *Frontiers in Global Women's Health*, *2*, p.708410.

[77] supra [67]

[78] UK Government Press Release, '*Survey reveals women experience severe reproductive health issues*' by Public Health England (26 June 2018), accessed at https://www.gov.uk/government/news/survey-reveals-women-experience-severe-reproductive-health-issues on 2 April 2023.; Report by Public Health England: *Reproductive Health: What Women Say, A consensus statement: reproductive health is a public health issue.*, accessed at https://www.gov.uk/government/publications/reproductive-health-what-women-say on 2 April 2023.

heavy menstrual bleeding, menopause, incontinence, and infertility. A factor which was particularly emphasised was the issue of stigma in the workplace. Previous studies have highlighted that 12% of women have taken a day off work due to menopause, but that 59% lied to their boss about the reason for their absence. The 2018 study indicated that 35% of women experienced heavy menstrual bleeding which has been associated with higher unemployment and workplace absenteeism. Thus, the stigma is a significant concern for women and impacts the health picture on a broader scale.

According to AHPMA,[79] there are around 15 million menstruating women in the UK. The average age when menstruation begins is 12.5 years of age and lasts around 37 years. It is estimated that during a lifetime a woman will menstruate roughly 500 times, which equates to roughly 6.5 years of a woman's life. A recent campaign-related study by WaterAid[80] revealed that 1 in 8 women in the UK do not know what menstruation is until they start their own. Therefore, not only is the lack of medical attention an issue, but also the lack of education. There are not only health issues, but also systemic issues at play in this debate. According to Royal College of Obstetricians and Gynaecologists ('RCOG'), cervical cancer is predicted to increase by 143% until the year 2040 – thus becoming one of the most significant threats to women's health. In such a context, focus on preventative care and early recognition is key to survival and full recovery.[81]

The health care system

The UK National Health Service ('NHS') was established in 1948, as four separate entities namely NHS Scotland, NHS Wales, NHS England and Health and Social Care in Northern Ireland.[82] Collectively, the four are internally referred to as the 'NHS' and are funded predominantly out of general taxation. Despite calls for universalised health care emerging in the early 20th century, post-WWII UK focussed heavily on building up the NHS as it is known today. The founding principles of the NHS at the time were accessibility, universality,

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[79] Absorbent Hygiene Products Manufacturers Association, *'Menstruation: Facts and Figures'*, publication date and author unknown, accessed at https://www.ahpma.co.uk/menstruation_facts_and_figures/ on 4 April 2023.; NHS, 'Periods and fertility in the menstrual cycle', publication date and author unknown, accessed at https://www.nhs.uk/conditions/periods/fertility-in-the-menstrual-cycle/ on 4 April 2023.

[80] WaterAid UK, '*New survey shows a lack of period knowledge across the UK, as WaterAid launches #PeriodProud campaign*' by Yola Verbruggen, published on 22 May 2018, accessed at https://www.wateraid.org/uk/media/new-survey-shows-a-lack-of-period-knowledge-across-the-uk-as-wateraid-launches-periodproud on 4 April 2023.

[81] Royal College of Obstetricians and Gynaecologists, Report: *Better for Women: Improving the health and well-being of girls and women* (2019).

[82] Ham, C., 2020. *Health policy in Britain: The politics and organisation of the National Health Service*. Routledge.

comprehensibility and based on clinical need. Effectively, the goal was to create a health care system in which everybody has access to treatment for a medical need which was delivered in a simple and comprehensive manner – regardless of whether you had the financial means to pay for it or not. This idea of state-funded health has permeated European health care particularly in the post-War era. The two areas of medical care which are excluded are dental care and optometry.

"That it meet the needs of everyone, that it be free at the point of delivery, and that it be based on clinical need, not ability to pay" [83]

Historical development of the NHS

The idea of a national health service in such a form emerged out of the Labour Party Conference in 1934, spearheaded by Sommerville Hastings. This was backed by the Conservative MP Henry Willink, who at the time was also the Health Minister. In 1944, he released a White Paper which circulated through parliament and the public press. In 1945, a Labour MP became the next health minister, Aneurin Bevan, who is credited by historians to be the person who made the NHS what it is today, in structure, conception and practice. Bevan's proposal was brought to Westminster in 1946 and adapted in the devolved nations not long after. It is argued that this was encouraged by the War, as the need for accessible medical care for all was extremely high. Despite Labour leading the campaign to develop the NHS, the Conservative parties are considered responsible for the devolved development of the NHS into four separate bodies, to aid local administration and authority. Since its establishment there have been several controversies, including the lack of coverage for dental and optometric care, as well as the fees carried by patients for prescription medication. This was changed and reversed under Churchill and Wilson at different stages.

The failing economics of the NHS

Financial and systemic problems

As much as the NHS has been considered a 'hallmark uniting the nation'[84], it has also been the target of significant critique.[85] Scholars have analysed and debated the NHS for decades,

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[83] "The NHS in England – About the NHS – NHS core principles". NHS.UK (23 March 2009), accessed 27 March 2023.

[84] Adams, Ryan (27 July 2012). "Danny Boyle's intro on Olympics programme". Awards Daily. Archived from the original on 6 February 2013. Accessed on 6 April 2023.

[85] The Spectator, 'The NHS has never been the 'envy of the world' by Kate Andrews, published on 5 August 2021, accessed at https://www.spectator.co.uk/article/the-nhs-has-never-been-the-envy-of-the-world-/ on 6 April 2023.; Hazlehurst, J.M., Logue, J., Parretti, H.M., Abbott, S., Brown, A., Pournaras, D.J. and Tahrani, A.A., 2020. Developing integrated clinical pathways for the management of clinically severe adult obesity: a critique of NHS England policy. *Current obesity reports*, *9*, pp.530-543.

particularly regarding the funding and the staffing, all exacerbated by the Brexit and by the Covid-19 pandemic. A further significant area of debate has been the NHS mental health efforts and the rising cost of care, which has increased exponentially over the years.

Regarding the finances, the NHS is one of the most well-funded health care systems on an international scale. In 2016, 10% of GDP was used to fund the NHS, which is the most amount of GDP spent on a public sector service.[86] In 2019, the UK spent 10.2% of GDP on the NHS, compared to 11.7% in Germany or 11.1% in France, thus, a comparable amount.[87]

Since its creation, the spending for the NHS has risen rapidly, and yet the lack of funding and mismanagement of funding that is available has been a significant debate over the years.[88] On average, there has been a 6% increase in spending every year since its creation, particularly high during the Blair government. This rapid rise in funding has, however, not solved the problems at the ground level, meaning that there are still low wages, overworked staff, and complex gaps in access to care. Part of the staffing crisis of the NHS was exacerbated by the Brexit, when a significant proportion of medical professionals (11%) were affected. A survey from 2017 indicated that the NHS has a record number of EU national staff,[89] thus making the effect of Brexit combined with the Covid-19 pandemic in quick succession a potent mix for disaster.

Systematically, the NHS has often been the target of harsh criticism too, highlighting issues across its history regarding poor medical practice, poor communication and patient care and many more.[90] In 2021, the UK dropped in rank from first to fourth in the NHS survey, falling significantly in two key areas: equity and access to care.[91] The Euro Health Consumer Index ranked the NHS against other European health systems from 2014 to 2018, alongside other similar wealthy and developed countries since 2000. This excluded the impact of the Covid-19 pandemic, and yet, the UK was near the bottom of most tables except households who

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[86] The King's Fund, 'How does NHS spending compare with health spending internationally?' by John Appleby, published on 20 January 2016, accessed at https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally on 20 October 2022.

[87] The Guardian, 'NHS crisis caused by Tory underfunding not Covid, say doctors' by Michael Savage, published 26 June 2022, accessed at https://www.theguardian.com/society/2022/jun/26/nhs-crisis-caused-by-tory-underfunding-not-covid-say-doctors on 4 April 2023.

[88] ibid; Maynard, A., 2017. Shrinking the state: the fate of the NHS and social care. *Journal of the Royal Society of Medicine*, *110*(2), pp.49-51.

[89] The Guardian, *'Record number of EU citizens quit working in NHS last year'* by Marsh, Sarah March and Pamela, published 30 March 2017, accessed at https://www.theguardian.com/politics/2017/mar/30/record-number-european-staff-quit-nhs-brexit-eu on 17 December 2022.

[90] Hendy, J. and Tucker, D.A., 2021. Public sector organisational failure: a study of collective denial in the UK National health service. *Journal of Business Ethics*, *172*, pp.691-706.; Black, N., 2013. Can England's NHS survive? *The New England journal of medicine*, *369*(1), pp.1-3.

[91] supra [85]

faced catastrophic health spending.[92] Surprisingly, in 2010, the NHS was ranked one of the most efficient health care systems in Europe but is now arguably circling the drain of meeting the basic needs of its patients.

Recent data highlights that one of the main issues for the NHS is the timely access to treatment: Mortality for cancer, heart attacks and stroke, was higher than average in the UK compared to other similar countries.[93] In 2019, the Times commented on a study by the British Medical Journal which reported that "*Britain spent the least on health, £3,000 per person, compared with an average of £4,400, and had the highest number of deaths that might have been prevented with prompt treatment*".[94] The BMJ study compared "*the health care systems of other developed countries in spending, staff numbers and avoidable deaths*". Thus, it was not so much the active care that was the problem, rather when it was accessible. It was the long-term treatment of severe and chronic illnesses which led to deaths under the NHS. Civitas published an International Health Care Outcomes Index in April 2022 which compared the health care outcomes in global health systems across 19 countries like the UK. The Index covered spending, major disease outcomes, life expectancy and outcomes for treatable mortality and childbirth. Across the 16 metrics, the UK ranked at the bottom four times[95] and in the bottom three eight times.[96] No other comparable country – in sociodemographic or economic terms - has such a poor record.

One of the major issues the NHS is facing is a lack of funds and a lack of staff. However, given that the UK has one of the highest levels of investment into the health care system in the European area, it seems to be more accurate to state that it is not a lack of funding but mismanagement thereof. According to a survey from 2022, only 36% of Britons are satisfied with the NHS.[97] The top three issues were the long-waiting times, lack of NHS staff and inadequate funding. The last time public approval fell to this level was in 1997. Blair's "24 hours to save the NHS" campaigned to highlight the years of NHS underfunding under the Tory government. Experts in the field have warned that by the end of the decade, a million

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[92] Civitas, 'International Health Care Outcomes Index 2022', by Tim Knox, published April 2022, accessed on 28 April 2023.

[93] The Kings Fund, 'How good is the NHS*?',* Mark Dayan et al, published July 2018 accessed at https://www.kingsfund.org.uk/sites/default/files/2018-06/NHS_at_70_how_good_is_the_NHS.pdf on 8 March 2023.

[94] Blakely, Rhys (28 November 2019). "NHS spends least on patient health". *The Times*: 25.

[95] ibid, for stroke, heart attack and colon cancer survival.

[96] supra [92]

[97] Nuffield Trust, '*Public satisfaction with the NHS and social care in 2021: Results from the British Social Attitudes survey'* by Dan Wellings et al., published on 30 March 2022, accessed at https://www.nuffieldtrust.org.uk/research/public-satisfaction-with-the-nhs-and-social-care-in-2021-results-from-the-british-social-attitudes-survey on 16 March 2023.

more health care and medical staff will be needed to meet the needs of a rapidly ageing population. Part of the problem is exacerbated by Brexit and the loss of a significant proportion of medical professionals. Another part, however, is the 2010 budget under the Osborne's government which cut the budget for training places for clinicians who would now be working professionals. This signified the biggest cut in budget to the NHS since WWII.[98] In addition to this, the pay cut of the current NHS staff in 2021 is also a massively contributing factor. Governments may point the finger at the Covid pandemic, but the NHS already had a 4.4 million-strong waiting list prior to the outbreak. There are fewer physicians, nurses, beds, and intensive care units compared with other similar nations.[99] The average number of hospital beds per 1,000 people in OECD EU nations is 4.6, but the UK lies at only 2.4. Not only in hospitals themselves, but the emergency response services are also in the trenches – accusations are rife that people literally 'die waiting' in cases of heart attack or stroke. The average ambulance waiting time is 78 minutes.

Theresa May made the $20.5 billion announcement in the summer of 2018[100] to commemorate the NHS's 70th birthday, promising an increase in 3.3% annually. However, according to multiple think tanks, this will not be enough to allow the NHS to modernise and improve care and address the workforce shortage. Instead, the current levels of care will be maintained with the increase in spending. Further, this £ 20-billion budget is only relevant to NHS England – not to the devolved nations.

Conclusively, despite the significantly financial and economic investment in the British health care system, there are still substantial and dangerous gaps in this service reaching the end-customer i.e., patients. In the context of the population and the statistics mentioned, women are those who suffer the most under this mismanagement. The lack of representation in clinical trials combined with poor education on female issues, amplified by stigma in the workplace creates an environment which is predominantly to female patients' detriment. However, the UK is growing and shaping through one of the most troublesome political and economic periods of the nation's history – and is doing so, in favour of women.

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[98] Open Democracy, 'Five political decisions that drove the NHS to the brink' by Adam Bychawski, published on 10 January 2023, accessed at https://www.opendemocracy.net/en/nhs-crisis-rishi-sunak-conservative-labour-austerity-privatisation/ on 31 January 2023.

[99] supra [68]

[100] BBC, 'NHS funding: Theresa May unveils £20bn boost' by Nick Triggle, published on 17 June 2018, accessed at https://www.bbc.co.uk/news/health-44495598 on 2 February 2023.

Progress: Three policies advocating for female patients

A significant step in the direction of gender equity in health care is demonstrated by three policy developments in the UK in the past 10 years. Firstly, the women's health strategy for England from 2022 and secondly, the implementation of free sanitary products across public spaces in Scotland in 2021.

Policy 1: Women's Health Strategy for England 2022[101]

In 2021, the Minister for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries, made a call for evidence[102] to back the government-led national women's health strategy for England. This was the first of its kind in British history[103] and received over 100.000 responses from the British public.[104] In her statement to the House of Commons Dorries said "[...] *The government's integration and innovation white paper[105] and our public health reforms will set the direction for a greater focus on integrated, person-centred care and prevention. We must ensure that this work delivers for women.*"[106]

The idea behind the call for evidence was to understand not only the real experiences of women in the health care system but also the primary areas in need of improvement. There is both an emphasis on increased information, quality and accessibility of care, education on women's health, maximising women's health in the workplace and ensuring that research and data support improvements in women's health.

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[101] UK Government, Policy Paper: Women's Health Strategy for England. Department of Health & Social Care (30 August 2022), accessed at https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england on 28 March 2023.

[102] supra [63] Ministerial Foreword – Nadine Dorries.

[103] supra [64]

[104] supra [63]

[105] UK Government, '*Working together to improve health and social care for all*' by Department of Health and Social Care (11 February 2021), accessed at https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all on 19 February 2023.

[106] supra [63] Ministerial Foreword – Nadine Dorries.

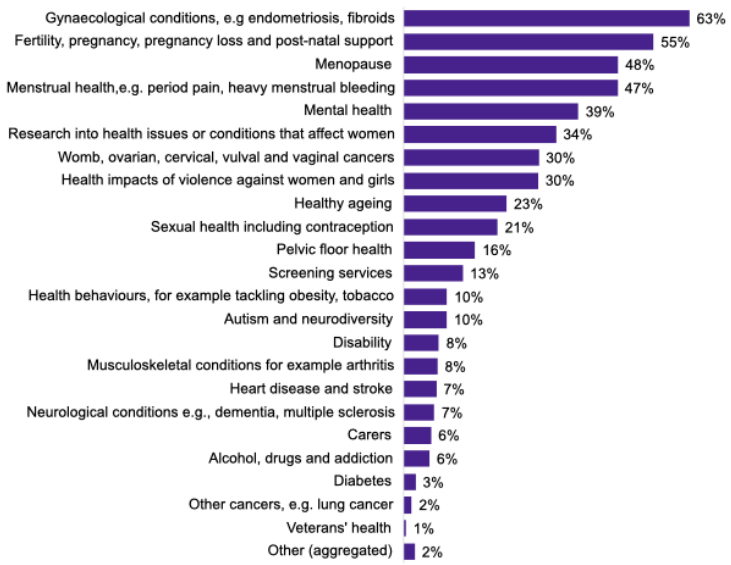

Figure 3: Which women's health topics do you think the Women's Health Strategy should cover?

The goal of the policy is to outline an improved women's health strategy for the coming decade, targeting five priority areas of respondents, namely gynaecological conditions; fertility, pregnancy, pregnancy loss and postnatal support; the menopause; menstrual health and mental health – demonstrated by Figure 2.

Further topics of research include health issues or medical conditions that exclusively affect women, gynaecological cancers, and the health impacts of violence against women and girls. A further element of the strategy is to increase the level of perceived comfort of women while talking with their medical professionals about their health issues, as well as increasing the level of education on women's health issues. The survey revealed that many women were gaining educational insights into their health from Google, the NHS website or friends and family. Only 24% of the respondents responded that they were able to get valuable health advice in a timely fashion, highlighting one of the major weaknesses of the NHS.

In summary, the strategy seeks to implement four key steps:

1.) Increasing access to accurate, usable, and evidence-based health information is the goal of this focus area to increase women's health literacy. It also strives to guarantee that medical staff members receive sufficient training on women's health issues. To tackle the stigma surrounding female health and to improve the approach to women's health issues, education at all levels is vital. This goes beyond the classroom and refers also to re-educating medical staff, updating online information, and focussing on educating about the impacts of female health in the workplace.

2.) Access to high-quality health care services for all women, regardless of their circumstances or background: This priority area strives to address health inequities and guarantee that all women have access to these services.

3.) Providing greater support for women's health requirements at every stage of their lives, from adolescence through menopause and beyond, is the goal of this focus area. Additionally, it tries to address specific problems with women's health, such as menopause, maternity health, and reproductive concerns. Viewing women's health as a lifetime-continuum is pivotal to understanding the health needs of women at different life stages from periods, childbearing, menopause, and the consequences of ageing.

4.) Maximising the impact of research, data, and innovation: This priority area seeks to advance women's health research and make sure that data and evidence are used to guide policy and practise. Additionally, it wants to encourage health care delivery innovations like the application of digital technologies and personalised treatment.

So far, the government has taken action to implement certain steps in this direction already, such as improving care for mothers and children from ethnic minority backgrounds and in lower socioeconomic areas, as well as investing further into maternity services. Regarding menopause, there has been a reduction in cost of hormone replacement therapy, one of the leading prescriptions to ease menopause symptoms. Virginity testing and hymenoplasty has also been banned, alongside the sale of Botox and cosmetic fillers for under 18-year-olds.

Thus, the Women's health strategy for England 2022 is a key step towards tackling structural and generational challenges relating to women's health. The 'Let's Talk About It' survey that preceded with it is the first of its kind and demonstrates a desire to meaningfully interact with women's health issues. However, as specific activities and results have not yet been fully realised, it is still unclear if the plan will be effective in bringing about genuine change. Additionally, the strategy's focus on maternal health seems to equate it with female health in general, which restricts its applicability and efficacy. While maternal health is a crucial component of women's health, it is not the only important elements; therefore, a more all-encompassing strategy is required to meet the whole spectrum of requirements related to women's health. All too often – as demonstrated by some of the family policy cited earlier – women are associated with motherhood and being mothers. The trend is moving away from this, and women deserve health as women, and not merely as mothers.

A significant issue with the strategy at this point is that it does not possess a defined action plan or next steps, which could lessen its effectiveness. Even though the strategy lists high-level initiatives like forming a women's health taskforce and building a women's health hub, it is not obvious how these initiatives would result in significant change. The plan needs to be backed up by practical efforts and interventions, with precise deadlines and implementation

goals, to be effective. Thus, in summary, while the Women's Health Strategy for England represents an important step towards addressing women's health issues, its effectiveness remains to be seen.

Scotland produced a similar policy proposal earlier in the same year,[107] which outlines a similar idea to focus explicitly on women's health. One of the key differences between the two is that the Scottish policy outlines a timeline for action steps to be taken in short, medium, and long-term goals. Wales and Northern Ireland have yet to publish a similar policy plan for women's health.[108]

Policies 2 and 3: Providing for periods

In this instance, the two policies are relevant to one another, as they both refer to the same level of need – products required during menstruation. The main reason such policies are considered a vital element of working towards gender equity is the emergence and rise of period poverty, and the biological inequity of women being born with a uterus that requires such products, which men lack. In the UK alone, it is estimated that 137,000 children have missed school due to not being able to afford the sanitary products required for menstruation. Both policies highlight progress in the direction of understanding female health needs and pro-actively reducing gender inequity.

Colloquially coined 'period poverty' describes the concept of not being able to afford sanitary products during menstruation. Period poverty has been described by campaigners in the field as going to the supermarket and having to make the choice between buying a box of pasta or a box of tampons. Both are basic supplies,[109] differentiated only by the expense of the latter being carried exclusively by women. This concept is given its own term due to the succeeding aftereffects it carries with it: inability to rely on such products often results in missing work, school, or university. In the UK alone, a report by Plan international[110] indicates that one in

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[107] Scottish Government, *Women's health plan* (20 August 2021), Department of Public Health and Women's health and Sport, accessed at https://www.gov.scot/publications/womens-health-plan/pages/11/ on 17 April 2023.

[108] Welsh Parliament, Senedd Research, '*Women's health in Wales: Welsh Government yet to implement women and girls*' health plan' by Sarah Hatherley, published on 8 March 2023, accessed at https://research.senedd.wales/research-articles/women-s-health-in-wales-welsh-government-yet-to-implement-women-and-girls-health-plan/ on 16 March 2023.

[109] BBC, 'Period Poverty: Scotland first in world to make period products free' by Claire Diamond, published on 15 August 2022, accessed at https://www.bbc.com/news/uk-scotland-scotland-politics-51629880 on 8 April 2023.

[110] Plan International, 'Dramatic Increase in Girls cutting back on essentials to afford period products amidst cost-of-living-crisis' by Rose Caldwell, published on 25 May 2022, accessed at https://plan-uk.org/media-centre/dramatic-increase-in-girls-cutting-back-on-essentials-to-afford-period-products on 7 April 2023.; Refinery29, 'More than 1 in 4 young women are struggling to afford period products' by Nick Levine, published on 29 May 2022, accessed at https://www.refinery29.com/en-gb/period-poverty-uk-young-women on 7 May 2023.

four (28%) of those who menstruate (14 to 21 years of age) were unable to afford period products. According to the same report, close to one in five (19%) have been unable to afford any period products since the start of 2022. The price of such products increased during the cost-of-living crisis, making them even harder to afford. A report by WaterAid highlighted that the struggle to afford sanitary products does not only affect young women, but also those between the ages of 14-50, of which nearly a quarter (24%) found it difficult to afford the products they needed.

The estimated cost of required sanitary products is £ 5.000,- of the course of a woman's lifetime. This is for one woman only. If there is a household of several women who are all menstruating, the cost of such products can be significant. A significant contributor to menstruation – aside from the involved physical process and pain – is the cost of sanitary products.

Policy 2: Abolition of the 'Tampon Tax'

In 2021, the 5% taxation on sanitary products was removed across the United Kingdom.

A significant challenge in this context is the EU-mandated 'tampon tax'. EU law required members to tax tampons and sanitary products at a rate of 5% since 2001. They were considered a 'non-essential item' and therefore were taxed differently. Such a mindset highlights the problematic and obvious masculine narrative of EU legislation. After Brexit, the UK as a non-member, was able to amend this regulation. A strong driver of this change was the campaign led by Laura Coryton entitled 'Stop Taxing Periods' which gained worldwide attention.[111]

Owing to EU law, across the region essential period items are taxed at a higher rate than other similar goods – known as the 'tampon tax'. The well-known 'pink tax' refers to higher tax bands on female products of which there is an almost identical product target at men. In many cases, it is not merely higher taxation, but also a higher price.[112] However, tampon tax is significantly more problematic, as it is related to necessary items for women who menstruate.

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[111] The Independent, 'Tampon Tax: How Laura Coryton started the 'Stop Taxing Periods' campaign while still a student' by Alice Hearing, published 23 February 2016, accessed at https://www.independent.co.uk/student/student-life/tampon-tax-how-laura-coryton-started-the-stop-taxing-periods-campaign-while-still-a-student-a6891336.html on 4 April 2023.; Change.org – Petition by Laura Coryton '*Stop taxing Periods Period. #EndTamponTax*.', started 19 Mai 2014, access at https://www.change.org/p/george-osborne-stop-taxing-periods-period April 4 2023.

[112] Habbal, H.L., 2020. *An Economic Analysis of The Pink Tax* (Doctoral dissertation, Lake Forest College).; Investopedia, '*What is the Pink Tax? Impact on Women, Regulation, and Laws*' by Amy Fontinelle, published on 3 March 2023, accessed at https://www.investopedia.com/pink-tax-5095458 on 8 March 2023.

In 2007, the EU permitted its member states to reduce this tampon tax.[113] Many nations have since reduced it, some have raised it, but the UK joined Ireland, Germany, Canada, and Australia by abolishing tampon tax entirely in 2021.[114] According to the EP in 2020, period poverty is still a significant problem across the region. It is estimated that 1 in 10 girls is not able to afford necessary sanitary products.[115] Some scholars argue that the abolition of the tampon tax will not have as significant an economic effect as it is thought to be, and that it will be the wealthy women that will benefit more than the poor, arguably those that were and are most affected by period poverty.[116]

Initially tabled by MP Christine McCafferty in 1999, the abolition of tampon tax has moved at a slow but steady pace. Under the Brown premiership the tax was reduced from 17.5% to 5% in 2001. Subsequently Osborne introduced the Tampon Tax fund to manoeuvre around the binding EU laws on tampon tax at the time. The fund was not free of controversy and was disbanded once the UK left the EU and was able to abolish the tax altogether.[117]

In the vein of the abolition of tampon tax being a step towards equality, one of the major criticisms has been the exclusion of period underwear. As a form of sanitary product which is particularly relevant to those with physical disabilities and mobility issues, the UK government's refusal to reduce tampon tax on such items has been a source of criticism.[118] Since this was initially changed in the UK, other countries such as the US, Kenya, Canada, Australia, India and Colombia have followed suit.[119] Within the EU, the taxation on sanitary products remains at minimum 5%. To this day, they are considered 'non-essential items'.

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[113] Statista, 'Where Tampon Tax is Highest and Lowest in Europe' by Katharina Buchholz, published 28 March 2020, accessed at https://www.statista.com/chart/18192/sales-tax-rates-on-feminine-hygiene-products-in-europe/ on 9 March 2023.; Lafferty, M., 2019. The pink tax: the persistence of gender price disparity. *Midwest Journal of Undergraduate Research*, *11*(2019), pp.56-72.

[114] CIVIO Medicamentalia, 'Half of the European countries levy the same VAT on sanitary towels and tampons as on tobacco, beer and wine' by María Álvarez del Vayo, published on 7 November 2018, accessed at https://civio.es/medicamentalia/2018/11/07/14-european-countries-levy-the-same-vat-on-sanitary-towels-and-tampons-as-on-tobacco-beer-and-wine/ on 5 April 2023.; UK Government, *News story: Tampon Tax abolished from today*, published 1 January 2021 by HM Treasury, accessed at https://www.gov.uk/government/news/tampon-tax-abolished-from-today on 5 April 2023.

[115] European Parliament, Parliamentary question E-006746/2020 'Period Poverty in the EU', published 10 December 2018, accessed at https://www.europarl.europa.eu/doceo/document/E-9-2020-006746_EN.html on 6 April 2023.

[116] University of Oxford Centre for Business Taxation, '*Why we should all worry about the abolition of the Tampon Tax*' by Rita de la Feria, published on 8 March 2021, accessed at https://oxfordtax.sbs.ox.ac.uk/article/tampon-tax on 6 April 2023.

[117] London School of Economics, 'A stain on equality: The UK's refusal to remove tax from period underwear' by Abbie Rawlings, published on 26 March 2021, accessed at https://blogs.lse.ac.uk/socialpolicy/2021/03/26/a-stain-on-equality-the-uks-refusal-to-remove-tax-from-period-underwear/ on 6 April 2023.

[118] ibid; Crawford, B.J. and Waldman, E.G., 2018. The Unconstitutional Tampon Tax. *U. Rich. L. Rev.*, *53*, p.439.

[119] Crawford, B.J. and Spivack, C., 2017. Tampon Taxes, Discrimination, and Human Rights. *Wis. L. Rev.*, p.491.

Policy 3: Free sanitary products across Scotland

In 2022, Scotland became the first country in the world to provide free period products to everyone who needs them.[120] This is a tremendous accomplishment in the context of UK health care and a significant step towards gender equity in health care. Councils and education providers are legally required to provide tampons and sanitary pads to anyone who needs them. The policy was proposed in 2017 by SNP Member Monica Lennon.[121] The MSP had been promoting ending period poverty prior to the proposal of the bill. The first step in the process of this policy was to introduce free period products at universities in Scotland from 2018 onwards.[122] The Period Products (Free Provision) Scotland Bill[123] was voted in unanimously on 24 November 2020. The bill now legally requires local authorities to ensure anyone who needs period products can obtain them for free. This includes universities, schools, public areas and so on. The access to the products should be simple and dignified, without a need for justification for needing the products. The driving force behind this was to eradicate period poverty as much as possible in Scotland.

In England, a similar policy was attempted for a trial period between 2020 and 2022[124] but this was only done in state-operated schools and educational facilities. This did not include universities. The argument by the government at the time behind reserving it for state-schools only was a 'service' for the taxpayer. Providing this type of offer universally was considered not to 'represent good value for taxpayers'.[125]

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[120] Happiful, 'What is period poverty (and how can I access free period products in the UK?)' by Bonnie Evie Gifford, published on 15 August 2022, accessed at https://happiful.com/what-is-period-poverty-access-free-period-products on 8 May 2023.

[121] Period Products (Free Provision) (Scotland) Bill (2021).; Thornton, J., 2020. Free period products in Scotland. *The Lancet*, *396*(10265), p.1793.

[122] Scottish Government, *News: Students to get free access to sanitary products, by Communities and Third Sector Fraction,* published on 24 August 2018, accessed at https://www.gov.scot/news/students-to-get-free-access-to-sanitary-products/ on 9 May 2023.

[123] supra [118]

[124] UK Government, *Period product scheme for schools and colleges in England*, Department for Education (8 September 2022), accessed at https://www.gov.uk/government/publications/period-products-in-schools-and-colleges/period-product-scheme-for-schools-and-colleges-in-england on 18 April 2023.

[125] ibid

Case Study 2: Spain

National health in Spain

Spain enjoys the highest life-expectancy in Europe and overall, the population tends to be healthy. The 2021 Health Care Index ranked Spain in the top 10 out of 89 countries[126] in overall health care provision. However, the Foundation for Research on Equal Opportunity granted Spain a moderate score in the same year.[127] According to the OECD, health care spending in Spain is lower than the EU average for Europe,[128] as demonstrated by Figure 3. The 2020 European Health Survey in Spain found that men report having a better state of health than women. Considering the population over 15 years of age, 79.3% of men and 71.9% of women rate their state of health as very good or good. The perception of good or very good health status decreases with age in both men and women. In the 15-24 age group, 93.9% of men and 90.7% of women perceive their state of health as good or very good. These percentages are 72.2% for men and 67.9% for women in the 55-64 age group. At older ages, the difference between the percentage of men and women declaring a very good or good state of health is accentuated.[129]

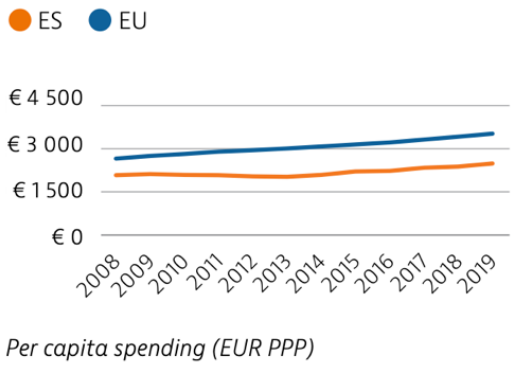

Figure 4: OECD Spain Country Health Profile 2021

[126] CEOWorld, 'Revealed: Countries with the best health care systems, 2021' by Sophie Ireland, published 27 April 2021, accessed at https://ceoworld.biz/2021/04/27/revealed-countries-with-the-best-health-care-systems-2021/ on 16 April 2023.; Commonwealth Fund, 'Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries' *by* Eric C. Schneider et al., published on 4 August 2021, accessed at https://doi.org/10.26099/01dv-h208 on 17 April 2023.

[127] FREOPP, 'Spain: #22 in the 2021 World Index of Health care Innovation' by Mark Dornauer, published on 25 June 2021, accessed at https://freopp.org/spain-freopp-world-index-of-health care-innovation-cf0a214e62e7 on 19 April 2023.

[128] OECD/European Observatory on Health Systems and Policies (2021), *Spain: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

[129] Instituto Nacional de Estadística, *Estado de salud (estado de salud percibido, enfermedades crónicas, dependencia funcional) (2021)*, accessed at https://www.ine.es/ss/Satellite?L=en_GB&c=INESeccion_C&cid=1259926692949&p=1254735110672&pagename=ProductosYServicios%2FPYSLayout&param1=PYSDetalle&param3=1259924822888 on 19 April 2023.

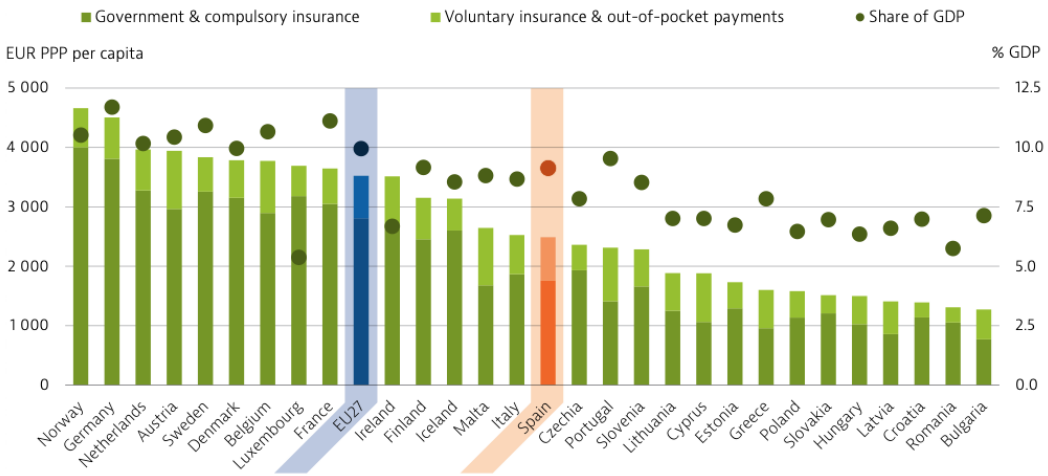

Figure 5: Spain spends less per capita on health care than many other EU countries, OECD Spain Country Health Profile 2021

In comparison to EU averages, Spain spends less per person on several types of health care, exemplified by Figure 4. In 2019, outpatient care accounted for 36% of Spain's health care spending, with inpatient treatment accounting for 25% of total expenditures. This is consistent with the country's relatively strong primary care system. Additional expenditures of 22%, which are greater than the EU average of 20%, were made on pharmaceutical treatment. Spending on preventive care is roughly half as much as the EU average of € 102,- at € 53,- per person. Preventable mortality rates in Spain before the COVID-19 pandemic were among the lowest in the EU, boosted by effective public health and prevention policies and low mortality rates from ischaemic heart disease (in particular among women), road accidents and other accidental deaths, and alcohol-related diseases.[130] Additionally, long-term care spending makes up a comparatively small portion of total spending (9.4% versus a 16.3% EU average).[131]

One of the key problems of women's health in Spain is the equality of access and affordability. Socioeconomic background is a significant problem according to experts.[132] In the context of reproductive health, women are often more affected by poverty in the health sector – as noted in the UK example, period poverty is a factor in Spain as well. Regarding female health specifically, one of the main sources of death for women are cardiac issues and stroke ('cerebrovascular').[133] According to the European Health Survey in Spain, over 70% of women

[130] supra [127]

[131] supra [127]

[132] Galindo E, Serrano N. Spain. Women in the world. Women's Health Newsletter. 1994, August;(23):8.

[133] Instituto Nacional de Estadística, *Deaths according to the most frequent causes of death – Year 2021* (2021), accessed at

had undertaken a mammography in the previous 2 years, and a further 20% had done so roughly 3 years prior. In Spain, data indicates that a smaller proportion (52%) of women over the age of 65 live in good health compared to their lifetime than men (63%).[134] According to the same survey, 55.5% of women aged 15 years and older have had a PAP smear less than three years ago. 24.4% of women (aged 15 and over) have never had a PAP smear.[135] For both cervical and breast cancer, Spain's survival rate is higher than the EU average.[136] In 2020, 74% of Spanish women aged 50 to 69 had undergone breast cancer screening in the previous two years, which is significantly more than the EU average of 59% in 2019.

Considering women's health specifically, Spain's gender equality index lies at 6th place in Europe, according to the EU.[137] Many of the statistics on female mortality or female health refer specifically to maternal health and maternal mortality. This highlights the trend within the EU as well, to recognise that female health and maternal health are two separate areas of action. However, one positive element within female health care in Spain to mention is the high-level focus on care for women with endometriosis. Thus, women in Spain are respectively to the rest of the EU healthier and can get regular checks for the female reproductive health needs. The women also seem to take advantage of these possibilities. However, context is key to any nation's health – in Spain, a significant problem is the health effects of domestic violence. Spain suffers one of the highest rates of domestic violence in Europe and is second highest in all of the OECD region.[138] December 2022 marked a 20-year high of femicide in the space of a month, costing 13 women their lives.[139] According to reports from the early months of 2023, an increase in domestic violence incidents of 9% per year has been noted in Spain.[140]

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https://www.ine.es/dyngs/INEbase/en/operacion.htm?c=Estadistica_C&cid=1254736176780&menu=ultiDatos&idp=1254735573175 on 19 April 2023.

[134] European Institute for Gender Equality (EIGE), Gender Equality Index 2021: Health in Spain (2021) accessed at https://eige.europa.eu/gender-equality-index/thematic-focus/health/country/ES on 20 April 2023.

[135] https://www.ine.es/ss/Satellite?L=en_GB&c=INESeccion_C&cid=1259926695829&p=1254735110672&pagename=ProductosYServicios%2FPYSLayout&param1=PYSDetalle&param3=1259924822888

[136] supra [127]

[137] supra [133]; OECD (2022), *Modernising Social Services in Spain: Designing a New National Framework*, OECD Publishing, Paris, https://doi.org/10.1787/4add887d-en.

[138] Eurohealth Observer, Volume 18, No.2 (2012), *Violence Against Women: The Spanish Response* by Claudia García-Moreno, accessed at https://apps.who.int/iris/bitstream/handle/10665/333033/Eurohealth-18-2-13-15-eng.pdf on 16 April 2023.

[139] Euronews, 'A dark month: Murder of women reaches 20-year high in Spain' by Laura Llach, published on 31 December 2022, accessed at https://www.euronews.com/2022/12/31/a-dark-month-murder-of-women-reaches-20-year-high-in-spain on 21 April 2023.

[140] The Times, 'Spanish domestic violence claims rise 9% in a year' by Isambard Wilkinson, published on 23 January 2023, accessed at https://www.thetimes.co.uk/article/domestic-violence-in-spain-up-by-9-in-terrible-rise-7tvlr0xzk on 21 April 2023.

Domestic violence disproportionately affects women[141] and in some cases carries severe health consequences with it – even death - making it relevant to the health care system from an economic and a health-related standpoint. Almost all of those who survive and surpass domestic violence require physical medical attention and very frequently the cost to mental health is severe. In the context of female health in Spain, this is an area that must be addressed, but it unfortunately is not in the ambit of this thesis and deserves a stand-alone analysis.

According to the Spanish Gynaecology and Obstetrics Society, a third of women who menstruate in Spain, suffer from severe pain.[142] In 2020, the ministry of health published an investigation focussing specifically on endometriosis, a disease responsible for crippling pain in women throughout their cycle. The prevalence of endometriosis can be estimated to be around 1-5%, and the incidence between 0.3-1.0% per year.[143] The document focusses on the development of an evidence-based report, with updated recommendations from quality clinical practice guidelines, for the care of women with suspected or confirmed diagnosis of the disease. This report would form the foundation of a proposal for organisational care model to be implemented into the health care system.

The ministry outlined the objectives of the report being to answer two key research questions:[144]

1. What diagnostic, therapeutic and follow-up interventions are recommended in the care of women with suspected or diagnosed endometriosis in quality clinical practice?
2. What organisational model of care is proposed for the care of women with suspected or diagnosed endometriosis?

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[141] Council of Europe, Prague Conference (2017), *Health and economic impacts of violence against women and domestic violence. Examples from Spain* by Cristina Fabre, accessed at https://rm.coe.int/spain-presentation-prague-conference-14-november-2017/16807689ec on 17 April 2023.

[142] Sociedad Española de Ginecología y Obstetricia (SEGO), Trabajo Original: Acceso sin prescripción médica a las píladoras de solo géstagenos. La vision de las mujeres españolas by I. Lete Lasa et al. (6 November 2022) Volumen 65, Número 6, p. 217-290.; The Local, 'OFFICIAL: Women in Spain first in Europe to get 'menstrual leave'' by AFP, published 16 February 2023, accessed at https://www.thelocal.es/20230216/official-women-in-spain-first-in-europes-to-get-menstrual-leave on 16 April 2023.

[143] Ávalos Marfil A, Barranco Castillo E, Martos García R, Mendoza Ladrón de Guevara N, Mazheika M. Epidemiology of Endometriosis in Spain and Its Autonomous Communities: A Large, Nationwide Study. Int J Environ Res Public Health. 2021 Jul 25;18(15):7861.

[144] Blasco-Amaro JA, Sabalete-Moya T, Carlos-Gil AM, Castro-Campos JL, Molina-Linde JM, Viguera-Guerra I, Rosario-Lozano MP. *Modelo de atención a las mujeres con endometriosis. Revisión sistemática de guías de práctica clínica.* Sevilla: Red Española de Agencias de Evaluación de Tecnologías Sanitarias y Prestaciones del SNS. AETSA, Evaluación de Tecnologías Sanitarias de Andalucía; 2020.

A further study on the prevalence and presence of the disease in the SNS highlighted that endometriosis - as recognised by the study – is incredibly difficult to diagnose, but when diagnosed arrives at an average of 22% of those undergoing medical testing, thus, almost a quarter of those tested have the disease.

The document recognises[145] that endometriosis not only has physical effects, such as severe pain, but that this in many cases affects the woman's ability to work, attend school or otherwise go about her daily business. The purpose is to highlight the need to amend and improve primary care for those who suffer from endometriosis. A systematic review has identified how endometriosis affects all dimensions of women's lives globally. Pain is the factor with the greatest impact on health-related quality of life and pain affects significant aspects of women's lives. It has many different characteristics, can disempower women, is associated with emotional problems, has a major effect on sexuality, and has a significant limitation on women's social life. Pain is also associated with significant losses in functional capacity and work productivity, both in terms of absenteeism and presenteeism.

A cost study has been carried out in Spain, which shows that endometriosis in women aged 15-64 years has an economic impact that can be estimated at around € 84.5 million, € 57.9 million in indirect costs (related to absenteeism, presenteeism and loss of leisure time) and € 26.6 million in direct medical costs (primary care visits, referrals to specialists and hospitalisations). This study did not include data on drug costs.[146]

Health care system in Spain: Instituto Nacional de Salud (SNS)

After the Spanish Civil War, a system of obligatory health insurance was established. It was originally based on a percentage tax linked to one's employment. The Franco regime then changed the system to a requirement for general social security,[147] which was expanded by several diseases and services. The SNS, as it is structured and recognised today, is based on the Law of General Health from 1986 as part of the Spanish Constitution post-Franco.[148]

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[145] Guía de atención a las mujeres con endometriosis en el Sistema Nacional de Salud (SNS). Informes, Estudios e Investigación. Ministerio de Sanidad, Servicios sociales e Igualdad. Paseo del Prado, 18 - 28014 Madrid, 2013.

[146] Estudio para conocer la prevalencia, morbilidad atendida y carga que supone la endometriosis para el Sistema Nacionalde Salud. Informes, Estudios e Investigación. Ministerio de Sanidad. Paseo del Prado, 18 - 28014 Madrid, 2020.

[147] Decreto 2065/1974, de 30 de mayo 1986.

[148] Ley 14/1986, de 25 de abril, General de Sanidad, BOE number 102 of 1986-04-29, pages 15207–15224. (Text of the law, in Spanish.)

The system has since been amended by various royal decrees, which mostly focus on affordability of care for the retired and elderly, as a point-of-cost issue.[149]

The SNS was founded by Spain's General Health Care Act of 1986. It guarantees universal coverage and free health care access to all Spanish nationals, regardless of economic situation or participation within the social security network. The core principles of the Spanish health care system are universality, free access, equity, and financial fairness. The SNS successfully covers 99,1% of the population and the rate of additional voluntary private insurance is estimated at roughly 10% of the population.

The SNS is mostly supported by taxes.[150] The country's total health care expenditure amounts to € 88,828 million, which accounts for 8.5% of the GDP. Public health care expenditure accounts for 6.1% of the GDP and represents an expense per inhabitant of € 1,421,-. The central government provides financial support to each region based on population and demographic criteria.

The current system consists of three organisational levels:

1. **Central (*Organizacion de la Administracion Central*)**

The Ministry of Health (*Ministerio de Sanidad y Consumo*), the state's central administration agency, oversees issuing health proposals, planning, and implementing government health guidelines, and coordinating activities aimed at reducing the consumption of illegal drugs.

2. **Autonomous Community (*Organizacion Autonomica*)**

Each of Spain's 17 Autonomous Communities (*Comunidades Autonomas*) is responsible for offering integrated health services to the regional population through the centres, services, and establishments of that community.

3. **Local (*Areas de Salud*)**

The "*areas de salud*" are responsible for the unitary management of the health services offered at the level of the Autonomous Community and are defined by considering factors of demography, geography, climate, socioeconomics, employment, epidemiology, and culture. To increase operability and efficiency, the areas are subdivided into smaller units called "*zonas basicas de salud*".

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[149] Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones.

[150] supra [127]

While the Ministry of Health continues to oversee national planning and regulation, the 17 regional health authorities have primary jurisdiction over operational planning at the regional level, resource allocation, buying, and provision.[151] They frequently depend on the assistance of specialised national organisations, including the Network of Agencies for the Evaluation of Health Technologies and Benefits.

High-level coordination of actions throughout the regional health systems is the responsibility of the SNS Interterritorial Council, which is made up of the national minister and the 17 regional ministers of health. Thus, any changes to the entirety of the health care system would need to be filtered through this council. The SNS has been decentralised since 2002, which has given the regional health care authorities the autonomy to plan, change and upgrade the infrastructure somewhat independently, making the system rather complex.

One of the major issues within the Spanish health care system is the financial burden on individuals. Spain was one of the founding members of the Valletta Declaration,[152] the international collaboration aiming to improve cost–effectiveness and decrease inequalities in access to medicines. The main goals of its pharmaceutical policies are aligned with the new pharmaceutical strategy for Europe adopted in November 2020.[153] To address shortages of medicines, in 2019 the SNS Interterritorial Council approved a plan by the Spanish Agency of Medicines and Health care Products to guarantee medicine supplies and improve coordination.

In the context of female health as a targeted area of policy, the government has created specialised units and drawn on organisations which campaign specifically in this area during policy creation. In 2010, Spain introduced a national strategy for sexual and reproductive health as the result of the consensus of scientific and professional societies, social organisations, the user population, experts, and representatives of the Autonomous Regions. The reasons for the creation of this were the numerous international treaties and agreements by the UN, WHO, EU, CEDAW which outline the necessity to target sexual and reproductive health specifically. However, this strategy is not directly targeted at women – it speaks

[151] Health Management, 'Overview of the Spanish Health care System', Volume 12, Issue 5/2010, author unknown, published on 20 December 2010, accessed at https://healthmanagement.org/c/it/issuearticle/overview-of-the-spanish-health care-system on 5 April 2023.

[152] supra [127]; OECD (2021), "Health expenditure in relation to GDP", in *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris.

[153] European Commission, Pharmaceutical Strategy for Europe (2020), COM(2020) 761 final, Brussels, 25 November 2020.

substantially about pregnancy and pregnancy-related health as part of reproductive health, but it was not specifically targeted at female reproductive health as it is understood in the context of this thesis.[154]

There have been various publications[155] over the years by public bodies and independent organisations arguing that a gender-perspective in health care is essential to effectively meeting health care needs. An example of such an organisation is the Women's Health Observatory.[156] Since its creation in 2004 and reactivation in 2019, the Observatory has focused on mainstreaming gender in health policies; addressing violence against women in the health sector; promoting sexual and reproductive health; and facilitating training in these areas for the whole of the SNS. The Observatory functions as an advisory and analytical body, which aims to analyse health policies and propose actions to reduce gender inequalities through sharing knowledge and understanding of the health of women and men, their problems, and their needs, to improve the functioning of the health system and the health and quality of life of citizens.
It has in the past proposed actions based on the national strategic plans for both Health and Equality, while at the same time developing the objectives set out in the UN SDGs 2030 Agenda for sustainable development in relation to gender equality and the empowerment of women and girls. It also addresses the measures related to the field of health and health care of the State Pact against Gender Violence, approved by the Congress in 2017.

As a further step in this endeavour, the policy which has now been implemented in Spain is the first of its kind in Europe: official sick leave for menstrual pain.

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[154] National Strategy for Sexual and Reproductive Health. Health care. Ministry of Health, Social Services and Equality. Paseo del Prado, 18 - 28014 Madrid, 2012. (English version of Spanish policy), accessed at https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/ENSSR_English.pdf on 10 April 2023.

[155] Arias, S.V., 2008. *Recomendaciones para la práctica del enfoque de género en programas de salud*. Observatorio de Salud de la Mujer.; Velasco Areas, S., Recomendaciones para la práctica clínica con enfoque de género. Madrid: Digital Solutions Networks SA [Internet]. 2009.; Ruiz-Cantero, M.T. and Papí-Gálvez, N., 2007. Guía de estadísticas de salud con enfoque de género: análisis de internet y recomendaciones.

[156] Observatorio de la Salud de las Mujeres, website: https://www.observatoriosaludmujeres.es accessed 10 April 2023.

Policy 4: Menstrual leave for period pain

"This is a historic day for feminist progress" [157] ***- Irene Montero***

As of 16th February 2023, the sexual and reproductive health bill – a progressive piece of women's health policy – which was introduced in Spain, will guarantee menstrual leave for period pain which is fully state-funded. The policy was part of a wider introduction of female health elements and has been hailed as a historic moment in feminist history for Spanish women. There are a limited number of countries in the world which offer menstrual leave, namely Japan, Indonesia, Taiwan, South Korea, and Zambia.[158] In Europe, Spain is the first nation to introduce such a policy.[159]

The draft bill was originally approved by the government in May 2022 and was confirmed in February 2023 by the Council of Ministers and the Congress of Deputies before finally being drafted into law. It was approved by 185 votes to 154 in the Congress, with three abstentions.[160] The main opposition came from Vox and Partido Popular, both more centre-right parties in Spain. The policy itself was backed by Podemos in collaboration with some pro-independence Catalan parties, which has been criticised in the press.[161]

One of the key driving forces behind the bill was Spain's Minister of Equality, Irene Montero, who has been advocating for women's rights and gender equality throughout her political career.

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[157] Montero, Irene, @IreneMontero "Hoy es un día histórico de avance en derechos feministas: la nueva Ley del Aborto y la Ley Trans de derechos LGBTI van a ser ley", Twitter, 16 February 2023 at 09:38 AM, https://twitter.com/IreneMontero/status/1626139063970398210, accessed 10 April 2023.

[158] Baird, M., Hill, E. and Colussi, S., 2021. Mapping Menstrual Leave Legislation and Policy Historically and Globally: A Labour Entitlement to Reinforce, Remedy, or Revolutionize Gender Equality at Work?. *Comp. Lab. L. & Pol'y J.*, *42*, p.187.; Le Monde, "Spain approves law creating 'menstrual leave' and allowing gender determination from 16" by Le Monde and AFP, published on 16 February 2023, accessed at https://www.lemonde.fr/en/international/article/2023/02/16/spain-mps-pass-a-law-permitting-gender-self-determination-from-16_6016069_4.html on 10 April 2023.

[159] ibid

[160] The Local, "Official: Women in Spain first in Europe to get 'menstrual leave'" by AFP, published on 16 February 2023, accessed at https://www.thelocal.es/20230216/official-women-in-spain-first-in-europes-to-get-menstrual-leave on 10 April 2023.; Politico, "Spain approves paid menstrual leave, first country in Europe to do so" by Nicolas Camut, published on 16 February 2023, accessed at https://www.politico.eu/article/bill-europe-spain-parliament-creates-first-menstrual-leave-in-europe/ on 10 April 2023.

[161] Euronews, "Painful periods? Spain just passed Europe's first paid 'menstrual leave' law" by Camille Bello, published 16 February 2023, accessed at https://www.euronews.com/next/2023/02/16/spain-set-to-become-the-first-european-country-to-introduce-a-3-day-menstrual-leave-for-wo on 10 April 2023.

The bill[162] itself introduces four elements into sexual and reproductive health rights:

- Abortions for girls aged 16 and 17 will be possible without parental consent
- The mandatory three-day reflection period before an abortion will be removed
- Abortion must be guaranteed in the public health system an accessible to all women
- Menstrual leave and pregnancy leave incorporated from the 39th week of pregnancy
- Free period products in public institutions to tackle period poverty

Despite the overarching nature of the policy, the focus for this thesis will be the provision of menstrual leave and free period products. More will be said about the nature of the policy in the analysis.

The menstrual leave policy initially granted women experiencing period pain 'as much time off as they need.' This time off is fully funded by the state social security system, not by employers. As with any other paid sick leave, a doctor must approve it. The duration of the sick leave in the official policy has been vaguely defined as 'a three-day medically supervised leave, with the ability to extend for those with disabling periods: severe pain, cramps, cramping, nausea, dizziness and vomiting".[163] Despite the mostly positive reception from the feminist community in Spain, the policy is not without its critics. Some argue that the policy should go further and that even regular periods can sometimes be debilitating, but that this is not recognised as illness but as fact.[164] This concern here lies with the needs for medical note from a doctor, which is thought to diminish women's agency in taking care of their own physical needs.

One of the strongest pushbacks to the bill has been the trade and labour unions. The concerns are that allowing women to take menstrual leave will result in further stigmatisation of women in the workplace. The Partido Popular highlighted that the policy could negatively affect the labour market to the detriment of women. Spain's other main trade union, Comisiones Obreras, supported the idea of menstrual leave and equally raised concerns regarding the scope of the medical note. The union voiced concerns over the details of the policy, and whether women would have to prove they suffer from a condition known to worsen period pain

[162] Ley 4/2023, de 28 de febrero, para la igualdad real y efectiva de las personas trans y para la garantía de los derechos de las personas LGTBI.; Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo.

[163] Articulo unico, articulo 5; Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo.

[164] supra [160]

- such as endometriosis or polycystic ovary syndrome - to claim this menstrual leave.[165] A further concern was the need to 'prove' one's physical discomfort with a medical note, leaving it in the hands of the doctors to decide if pain is 'disabling' and how many days of sick leave would be needed. Given that many of the illnesses of the reproductive system – such as endometriosis or PCOS – remain highly difficult and time-consuming to diagnose, the union expressed concern that this could hinder women from getting access to the menstrual leave in times of need.

[165] supra [160]

Comparative analysis

Understanding both case studies is imperative to recognising and highlighting their respective differences and similarities. Primarily, the countries will be compared using their demography, before highlighting the similarities between the various policies which have been implemented. Subsequently, the discussion will focus on their differences. These differences will be particularly relevant in the recommendations, as the learning from both policies is what will drive any and all future developments in female-focussed policy.

Both the UK and Spanish health care system are funded by general taxation, known as Beveridge Systems;[166] both have the opportunity to register for additional private insurance, which grants access to other doctors, facilities, and sometimes shorter waiting periods. Concerning the expenditure on health care, the UK spends significantly more on their health care per capita, as well as based on individual costs.[167] The UK also has one of the highest expenditures in this sector in the OECD region. Despite this significant investment, UK health care does not have a strong reputation or high service quality and outcomes. The UK health system is currently 'falling apart at the seams' in every way possible.

Spain - comparatively - boasts one of the healthiest populations in Europe, even with notably lower health care costs. Despite investing less in this sector, the access to care and statistics is significantly better than in the UK. An aspect which must be factored into this debate is culture – Spain is culturally more collectivist than the UK, thus the focus of care often lies within families. Children and grandchildren are unofficially expected to care for their elderly family members, and in many instances, the elderly live with a family at home, as opposed to being put in a care facility, as would be more typical in the UK. In the context of a rapidly ageing population across Europe, this is a necessary factor in the calculation of costs of health care.[168]

Both nations note a higher life expectancy for women – this higher life expectancy average correlates to the European norm. Where the figure differs is in the context of quality of life for these women. Merely because women are living longer in these countries, does not mean they are living in good health or receiving quality care. British women may live longer than

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[166] Or, Z., Cases, C., Lisac, M., Vrangbaek, K., Winblad, U. and Bevan, G., 2010. Are health problems systemic? Politics of access and choice under Beveridge and Bismarck systems. *Health Economics, Policy and Law*, *5*(3), pp.269-293.

[167] supra [85]

[168] United Nations Population Division, *World Population Prospects 2019,* https://population.un.org/wpp/Download/Standard/Population/, and Toshiko Kaneda, Charlotte Greenbaum, and Kaitlyn Patierno, *2019 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2019).

Spanish women, but these additional years are spent living with poorer life quality. Spain, in particular, has a higher percentage of women accessing passive health care, such as regular cancer scans and checks. In the UK, the statistics for this are below the recommended medical average as well as below the European average.

One of the areas in which the UK is growing significantly – despite the numerous complications in the health care system – is the technological advances which are increasingly implemented into the health care system.[169] Despite this, the high-level advances are yet to be translated into a format where they support the patients on the ground. Comparatively, Spain is still lagging in terms of digital advancement of health care.[170] In recent years, the focus has been on creating electronic health records which are transferrable and expanding the telemedicine structures within the nation, but compared to the UK, Spain still has a significant room for growth in this area.

Policy comparison

Both primary policies are 'firsts' – the introduction of menstrual leave has existed in select few countries across the globe but had not yet seen success in Europe until Spain. The provision of free sanitary products to such an extent i.e., being available in public areas openly, is the first of its kind globally. Other nations, like England have trialled this type of policy for a limited period but this is the first major step towards gender equity in health care and female-focussed health care. Despite the Spanish policy also stipulating that the cost of sanitary products should not be a hindrance to any woman who is in need, the policy does not focus on the provision of sanitary products, but rather focusses on aiming to eradicate period poverty. However, this is not a central tenant of the policy, unlike the policy from Scotland.

The overall health policy highlights that female health should be approached as a life-long journey and takes a more holistic approach to health care and inclusion of female-specific health issues. Thus, the policies as a collective demonstrate a deeper understanding of the needs involved in female health care and seem to place active steps in the direction of addressing these problems with concrete steps. This is best exemplified by the Scottish policy, but the other policies highlighted from England are equally valuable at setting the tone of amendment and recognition. Therefore, in summary, the UK policies are more expansive.

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[169] Ghafur S, O'Brien N, Howitt P, Painter A, O'Shaughnessy J, Darzi A. NHS data: Maximising its impact for all. Imperial College London (2023).; Policy Links (2021). UK Innovation Report. Benchmarking the UK's Industrial and Innovation Performance in a Global Context. IfM Education and Consultancy Services (IfM ECS). Institute for Manufacturing, University of Cambridge.

[170] Alvarez-Galvez, J., Salinas-Perez, J.A., Montagni, I. et al. The persistence of digital divides in the use of health information: a comparative study in 28 European countries. Int J Public Health 65, 325–333 (2020).

The Spanish policy takes a broad approach to female health care, by creating a policy which addresses multiple concerns in one swoop. However, this means that the individual aspects mentioned in the policy are not necessarily strongly defined in their goal or quantified in terms of priority. An overview of the writing about the policy implementation across the Spanish press would hint that the 'key' areas of concern for women in Spain are abortion and menstrual leave. Given this broad approach to female-focussed policy, which includes abortion, highlights elements of Europeanization. In the European health care writing and policies, female health and maternal health are often correlated or used interchangeably. In some instances, it is only maternal health that is referred to. Spain plays into this by rendering maternal health (abortion and pregnancy leave regulations) and menstrual leave (female health) as equally important in its policy making. Female reproductive health far exceeds pregnancy-related matters; menstruation is a constant and consistent process in female bodies – the UK policy recognises this better and more 'objectively' than the Spanish policies. However, one strong example from Spain in the direction of gender equity in health care is the government-mandated report about endometriosis. Given the estimated rise in prevalence of endometriosis in the coming decade, the length of diagnosis and the lack of cure, this makes it one of the most pressing female health issues moving forward. However, it is only one of the illnesses or symptoms that can befall women during their menstrual cycle.

The main problems with the policies are two-fold. The most beneficial policy in the UK is the Scottish policy, but it is, unfortunately, only applicable to Scotland and a roll-out in England has not been publicly discussed. The policy from England is a good roadmap, but it lacks concrete structure and next steps to make the changes the policy suggests tangible, effective and measurable, particularly as it lacks any mention on a timeframe for these policy implementations.

Concerning the Spanish policy, the main problem with the menstrual leave policy is the issue of independence of action for women who suffer from menstrual pain. For some – like those who suffer from endometriosis – during their cycle, the pain can be debilitating enough to make leaving the house impossible. In such situations, a policy that mandates available menstrual leave, but requires the person suffering to visit a doctor's clinic, is not only counterproductive but also counterintuitive. It places the power in the hands of the medical professional, as opposed to trusting women with the governance over their own bodies, symptoms, and needs. The policy is a good first step in a helpful direction towards female-focussed health care policy, but to be a true example of gender equity, the requirement for a doctor's note, as well as the requirement for the pain to be 'regular' ought to be changed. The menstrual cycle is one of the most complex and delicate processes in the human body, and many aspects of it still remain

poorly understood. Some women suffer unbearable pain every month like clockwork, others only every few months, or once a year. The possibility to still receive menstrual leave in situations when suffering from pain is not the norm for the woman, but unexpected and unforeseen, is equally as important. In striving for equity, this should not only be between men and women concerning their health care needs, but also for women with different needs.

Creating a health care system that has the ability and capacity to operate in such a way is a mighty undertaking and therefore a lofty goal. It is – however – equally as important to consider when thinking of long-term change in health care policy and policy creation. This will be discussed in greater detail in the recommendations.

Considering elements highlighted in the theoretical framework – in particular Europeanization – this applies mostly to the Spanish example. Considering the EU health policies, the overwhelming majority speak about 'maternal health' rather than 'female health', highlighting strong underlying masculinity power dynamics. Assuming that maternal health is the only health care that women require diminishes women to child-bearers. Particularly now, when birth rates are declining across the European continent, this is not only a disservice to women, but a lack of recognition of their needs. This terminology of maternal vs. female is replicated in Spain in some of the documentation regarding the health care system, thus, highlighting aspects of Europeanization and masculine bias in policy making.
A notable aspect in both the British and the Spanish health care examples is the high presence of masculinity in the policy making process, both positively and negatively. One of the first opening statements of the English policy is by Matt Hancock, whereas one of the biggest negative voices against the Spanish policy were male politicians, arguing that the policy for menstrual leave would disadvantage women on the job market.

None of the policies specifically discuss gender equity, but particularly the British examples highlight an understanding of equity disguised and termed as 'equality'. Affording women specialised care for different stages of their life is a perfect example of what gender equity in health care should look like. A girl in her teens will need vastly different care to a labouring mother or to a woman going through menopause, and meeting these needs as and when they arise in a phase of life is the primary example of equity over equality. There does seem to be a recognition in both countries that men and women have different physiological needs – and yet, in the case of Spain, this is dealing with only peripheral problems; the UK is tackling these situations head-on – at least in theory.

Recommendations

Considering the empirical findings and comparative analysis, the next – arguably most important step – is to highlight what relevance this information has, what opportunities for progress it highlights. The issues of female health, and female reproductive health, are largely systemic issues. Generations of lack of knowledge, acceptance of misunderstanding and mistreatment have been the norm in women's health care. Systemic inequalities also require systemic solutions and changes.

Education

Across the policies in both nations – and to a slight degree in European health policy – a major factor at creating change in this area particularly is education. Education in this context is important in two aspects; firstly, medical research and development must adapt to incorporate greater understanding of the female reproductive system and its impact on wider female health. Without increasing and narrowing down in the research field, the educational field cannot grow. Secondly, this knowledge must then be translated into curricula in both the medical field as well as general education. It is well-known that education for women – and for men – improves female health, increases reproductive autonomy, and increases female life expectancy.[171] Thus, creating a culture of awareness of female health will start in education and trickle through the rest of society, thus this must be a focal point going forward.

Policymaking on the basis of medical knowledge

Particularly given that, historically and currently, female health has not been a factor in medical and pharmaceutical research poses a significant challenge to furthering gender equity in health care. Thus, as research, knowledge and understanding of female health care expands and improves, this should shape policies which are created regarding female health, especially regarding female health. Spain provides an example in this regard, as it conducted a survey and enhanced research into endometriosis, a growing problem for women's reproductive health care. However, the insights gained from this have not been fully incorporated to the degree necessary. This is visible by the need for a doctor's note to access menstrual leave, for those who experience high-levels of pain regularly – the female cycle is not necessarily predictable for all women, particularly those who suffer diseases and illnesses of the

[171] supra [32]

reproductive system – such as endometriosis – and the pain main be too debilitating to leave the house, let alone for a doctor's visit. Thus, the research and the insights have been gained, but the translation of this into effective policy is still lacking. In addition, not every woman who suffers from problems or issues related to their menstruation are 'ill' – many times there is no explanation for such causes, as the medical research is limited in this field. Thus, requiring women to get a sick note for menstrual leave labels something that is a 'natural occurrence' for many as something that is an illness.

Awareness of digitalisation of health care

As technology progresses and further permeates the health care sector, this creates tremendous opportunity for growth and progress. However, particularly with the expansion of Artificial Intelligence ('AI') and automated learning into the health care system, it is vital to recognise and pre-empt the risks that this technology can pose for achieving gender equity. AI has already been known to replicate racial and gender-based biases via its algorithms and automated learning processes. Thus, when implementation of AI is at a rapidly growing pace, this risk is something to bear in mind when translating new policy or new health care findings from research into practice. The risk is that these technological advances can exacerbate gender differences more than alleviate them.[172] In this vein, the goal is not to focus on gender-blindness and treating all people as 'patients' but recognising differences and adapting care to these differences. Health systems should not aim for gender-blindness, but for gender equity in the health sector.[173] Addressing women's health needs goes beyond moving away from discriminatory practices and must be active about shaping policy that is female-focussed – this applies particularly as technology is being programmed that precisely fosters such changes to the health care system that move further away from gender equity, as opposed to towards it.

Priority must be women's health as a whole

As has been discussed, there has been a trend towards equating women's health with maternal health, diminishing this to purely those who are reproducing. Whilst there is still a high proportion of women which require maternal health support, this is not all women. If the

[172] supra [23]

[173] World Health Organisation, Regional Office for Europe. *Beyond the mortality advantage – investigating women's health in Europe*. Copenhagen: WHO Regional Office for Europe (2015) accessed at http://www.euro.who.int/__data/assets/pdf_file/0008/287765/Beyond-the-mortality- advantage.pdf?ua=1 on 20 May 2023.

goal is to work towards gender equity, this means recognising that women are more than people who give birth. The complexities of the female body – and particularly the female reproductive system – are intricate and multifaceted and require medical care as much as those who are budding mothers. Especially given that birth rates are declining collectively, the focus cannot and should no longer be maternal health over women's general health. Primary care for women that is adapted to their physiological need – regardless of their age and stage in life – should be the focus and the goal.

Conclusion

How would the female population of the European area benefit if a gender equity approach was adopted into national health care policy?

From longer lives to poorer health, to enforced poverty and unmet medical needs – women have been dealt the short-straw in health policy since its conception as an area of political practice. The theoretical elements of inequality, inequity and masculinity have highlighted how the entire system surrounding the creation and operation of health policy further disadvantages women by denying tangible differences between male and female reproductive care needs. The Westernised, developed world is by many accounts a glowing example of female empowerment, and is often used as a hallmark or standard for developing nations, for progress – and yet, even in some of the most developed and progressive nations, women face consistent gaps in their medical provision and care. In 1977, a quality-of-life survey from the UK[174] highlighted that providing women with disposable hygiene products was the second most impactful benefit of the 20th century for quality of living. Such hygiene products that allowed women to leave the house without shame, stigma or worry revolutionised women's lives – until they became taxed as luxury items or as non-essential goods, and thus, too expensive. Examples, such as Scotland, are fighting actively to change this systemic issue. "The days of (women) going to work in pain are over"[175] said the Minister for Equality in Spain as they proudly introduced their female-focussed policy for menstrual leave. Despite its gaps and inefficiencies, it is a starting point for progress and positive developments in favour of the most disfavoured majority – the female population.

Thus, women's health is not just a women's issue[176] – it is a systemic, societal, policy-level issue which must be addressed. When women and girls receive the education, the hygiene products, the medical care they need – by dint of their biology – then and only then has the playing field been levelled to a sufficient degree to speak about equity: recognising different bodies require different levels of care at different stages. President of the RCOG, Leslie Mann, argues that when care for women and girls is 'done properly', everybody benefits.[177] In an ideal world, more changes, and developments towards gender equity to benefit women's

[174] supra [79]
[175] supra [160]
[176] supra [106]
[177] supra [81]

health would be taken purely because it is the right thing to do – practically, there must be an economic, measurable, tangible benefit in the eyes of policy makers. This thesis has highlighted that women who are informed and involved in their own health care are better parents to children and better employees.

Thus, to conclude and answer the research question: the female population would benefit tremendously if gender equity were to become the new standard of health care – in education, research and development and medical practice. Gender equity in health care would be the first time that female health needs were truly and genuinely recognised, accepted, medically understood, and effectively treated. Not only for women – but for society in general, the odds improve. Changes to this effect very often need to happen on a smaller regional scale to have impact in greater circumstances – Scotland has set the path for the rest of the UK; Spain is a trailblazer within the EU. What would ideally happen in the future is that these nations set an example for wider regions – the EU, the Commonwealth nations, the European Economic Area.

Women make up more than half of the population of the globe and yet remain underrepresented in political, governmental, and decision-making positions and institutions. Growing recognition of female-specific issues, challenges, and hurdles in the workplace, in family life and as parents is slowly but surely changing the situation for women for the better – health care as one of the most influential topics in European politics and for the average citizen, should not and cannot be an exception to this progress.

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Appendix

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