PAUL DE RAEVE, ALEXANDRA CHARLES, AND PEGGY MAGUIRE UNDERLINE THE ROLE OF WOMEN IN SETTING THE INTEGRATED CARE AGENDA

Women: setting the agenda

European health systems face a number of major challenges moving forwards, including significantly reduced budgets, increased demand from an ageing population, and an increase in the number of people with chronic illnesses. The health system in many instances is no longer meeting the needs of patients, or at least meeting them fast enough, and is not delivering value for money.

We cannot ignore the need for change and the urgent need for a strategic vision for reform. In EU member states these reforms are ongoing and multilevel, but fragmented: small elements of the system are changing (e.g. chemotherapy moving to homecare in Belgium), but a clear, innovative research plan and both medium and long term visions on how the health and social ecosystem should become integrated are missing. Health service reform therefore requires a focus on integrated services that are co-ordinated and patient-centred, moving from a situation where many people are treated in hospitals when they could be treated in the community.

It is within this political context that women can play an influential role in the form of an agent for positive change, designing an innovative health and social care ecosystem. However, new technology and innovation are often not 'gender neutral': solutions are ill-adapted to the needs of women who occupy multiple roles such as workers, mothers and wives, family managers, and carers of the elderly. Given these constraints, it is important that the innovation and research agenda incorporates eHealth solutions that are user-friendly and tailored to women's specific roles and responsibilities, also in the workplace.

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Upscaling integrated care

Presently, many member states are introducing reforms to the health and social sector that are designed to improve the relevance, sustainability, efficiency, and cost-effectiveness of the current 'silo system', which is not sex and gender sensitive. The objective has to be to move to an upscaled integrated care ecosystem in which health and social care policy leads to better health and wellbeing for all EU citizens, taking into account the interaction of sex and gender. Health systems that take account of the interaction of sex and gender are more likely to be successful (Payne, 2009). Women and men use health and social care differently, and their experience of the ecosystem is shaped by gender differences in factors that lie outside of the system, such as employment and family roles.

'Integrated care' refers to the management and delivery of health services so that citizens receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health and social system (EIPAHA, 2012). Women in society have direct access to the daily care continuum needs of people of all ages – from children to older adults – and therefore have a key role to play in the design of policies that can transform the health and social care systems in the European Union.

Continuity of care designed through the eyes of women constitutes an effective vehicle for health and social policies that enable a flexible and controlled reform of the current traditional medical system towards a model of integrated care that is innovative, gender sensitive, and sustainable.

Mastering sex and gender

'Sex' refers to the biological and physiological characteristics of being male or female, while 'gender' refers to behaviours, roles, expectations and activities that a society considers appropriate for women and men. Sex and gender (S&G) are recognised as important determinants of health for women and men as they can influence their

access to health services and/or how health systems respond to their different needs.

Although the overall health of the EU population has improved over recent decades, that improvement has not been experienced equally everywhere or by all. Large health inequalities exist both between and within EU member states. Consequently, mastering sex and gender in the upscaling of existing models of integrated care is needed to make continuity of care the architectural model by which the IT specialists, the health professionals, end users and politicians remain on the same page so as to prevent future fragmentation.

An integrated care road map designed by frontline staff, designed by women, is one of the opportunities to get it right. In order to build a resilient health and social ecosystem, women need to have a stronger policy voice in the design of continuity of care, facilitating the reforms of the health and social sector.

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Towards a humane health and social ecosystem

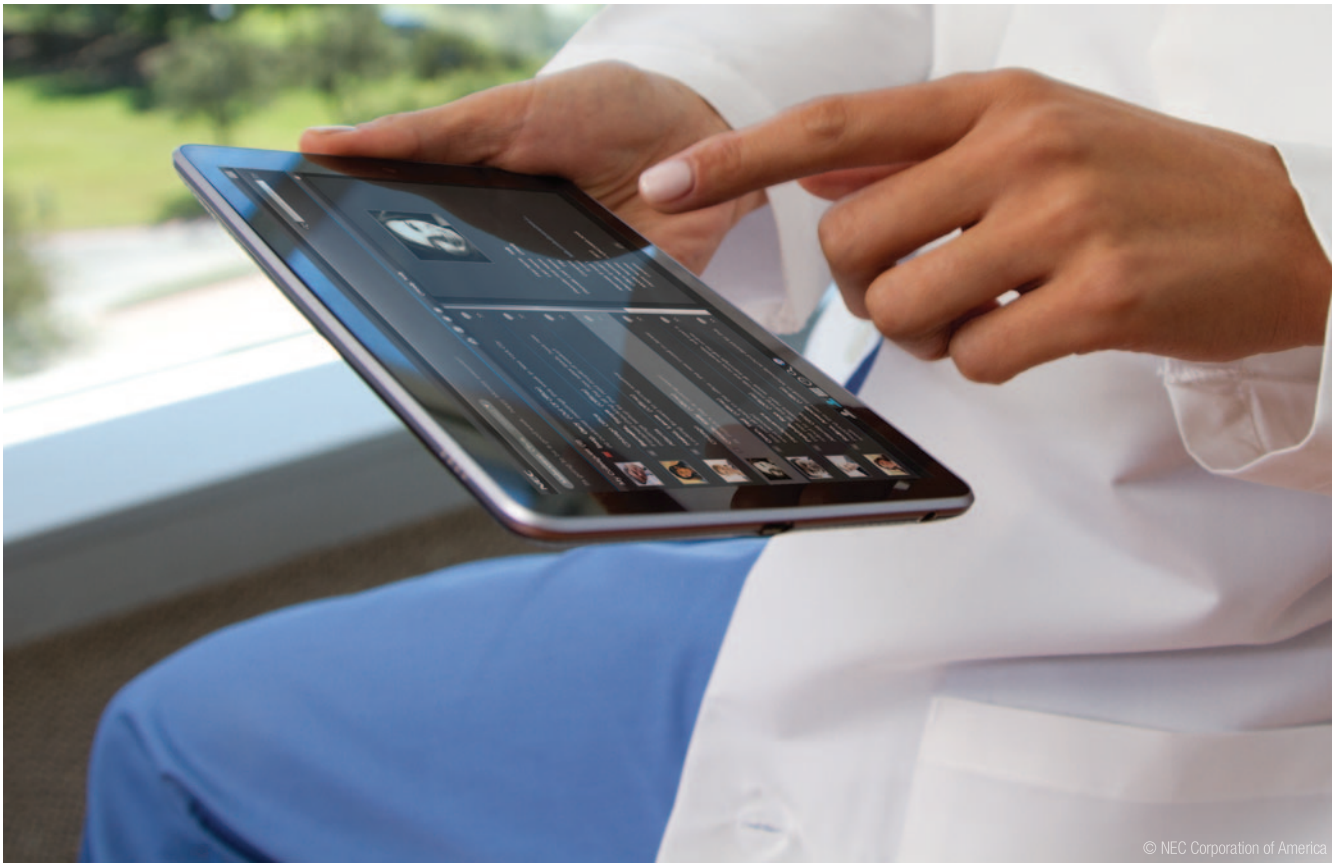
The mainstreaming of sex and gender concerns into the planning, delivery, monitoring, and evaluation of health and social services, including eHealth, should not be a complex process, as women working in the system are sensitive to the existing 'gender blindness' of the current decision-making processes. If the goal of developing gender-sensitive policies is to be achieved, this needs to be built explicitly in the design of services that can be used for evaluation purposes feeding into the European Semester.

The female voice in the European Semester is key for change. As the challenges in different sectors, particularly those related to health and social care, are tackled by the European Commission by analysing the state of play and making recommendations to improve performance, all member states need to make a series of political priorities that reshuffle investments towards building a humane health and social ecosystem.

Gender mainstreaming is therefore key for the design of new policies driving change towards integrated care. As such, gender mainstreaming goes beyond comparing the number of males and females, assessing gender patterns in service use, and even beyond the focus on women's and men's health. Instead, the gender perspective is a conceptual tool to enrich explanatory models of integrated care, supporting the design of health and social care policies and services, including eHealth.

Integrated care encompasses a range of dimensions spanning from the availability, the accessibility (e.g. community care), affordability (who pays what), acceptability with reference to their appropriateness (eHealth for managing chronic diseases), and the adequacy of services.

Even when citizens/patients do access health and social services (including prevention schemes), and do get to see a health or social care provider, they may not be able to access good quality and safe care due to the fact that the policies (even financial ones) surrounding the designed services may not consider the gender perspective. The gender dimension



of integrated care signifies an important shift away from the narrowly defined quality of health and social care, in terms of technical and clinical competence, towards a broader acknowledgment of interpersonal communication between providers and citizens/patients.

Valuing the 'software' of health systems

Health and social system reforms have mainly focused on the 'hardware' of such systems (i.e. the infrastructure, the technology, the economics) and less on the 'software' (i.e. the human and gender aspects). However, any reform of health and social care systems, towards integrated care, fails to take account of the everyday organisational reality of what happens at the bedside, in the community, and of the fact that health and social care professionals are neither cyborgs nor angels who implement policy unthinkingly.

People's experiences in using health and social care, including eHealth services, stay shaped by the nature of the relationship with the health and social care professional. It is within this context that nurses, most of whom are women, play a crucial role in making integrated care gender sensitive.

We should not make the same mistakes when transforming the Semashko model into the medically dominated model, strengthening the focus on diseases and high tech health institutions. As Europe is facing a rapidly ageing population accompanied by an increase of people living with long term conditions, disabilities, non-communicable diseases (NCD), chronic diseases, and multi-morbidity (Eurostat, 2012), the health and social care labour force, including the informal carers, will need to manage the delivery of patient-centric care differently (Kelly, 2005; WHO, 2010), with women's roles strengthened in leading change, making the ecosystem more effective (EU Council 2010). It is time to move care back to the community and to make its design more gender sensitive. Therefore, it is necessary that health, social and political science includes more evidence from women's frontline leadership than is currently the case.

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Investing in gender sensitive policies that establish integrated care, moving care outside of hospitals into the community, establishing a solid multi-professional dialogue and empowered decision making processes will not only develop sustainability but, more importantly, will harness the energies of frontline staff. Any transformation towards integrated care requires leadership, and that must come from frontline staff, whether or not they play formal management roles.

Nurses not only make the frontline decisions that determine the quality and efficiency of care, but also have the professional knowledge to help make sound strategic choices about longer term patterns of health and social care delivery. Unfortunately, powerful gender barriers hold back these developments. To design and deploy integrated care, it is essential to ask: Who makes and influences health and social care policy, planning and management decisions?

Moving forwards

To date, health and social care reform has been largely blind to its impact on gender equality: it has failed to sufficiently identify the distinct health needs and experiences of men and women, analyse the factors that contribute to that difference, and respond accordingly. Without such analysis, innovation and research can miss important opportunities to promote gender equality, and also negatively impact on women's (and men's) health.

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Building gender equality in health and social ecosystems improves their functioning and responsiveness with the goal of improving health outcomes. Furthermore, emerging research suggests that gender equality facilitates broader social and economic wellbeing, as well as stability (Percival *et al.,* 2014).

We know that the lives of women and men – including their income, patterns of participation in the paid and unpaid labour force, their time use patterns, the changing nature of their work, and their financial and emotional capacities to assume and sustain care – are different. As we move towards enhancing services outside the acute sector and boost continuity of care between hospitals and the community, it is critical that we consider these differences.

Including a gender perspective in health and social care must include improved health literacy and empowerment to shared decision making between provider and citizen/patient, which means active participation throughout the health and social care process. This in turn implies strengthening the multidisciplinary integrated care model as opposed to the traditional doctor-centred model of treatment.

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Paul De Raeve
EFN Secretary General

http://www.efnweb.eu/

Alexandra Charles
Chair of the 1.6 & 2.6 Million clubs

http://www.1.6miljonerklubben.com/english/

Peggy Maguire
Director General European Institute of Women's Health

http://eurohealth.ie