It’s ***JUST*** inequalities in health.

How can we improve the healthcare experience of ***WOMEN?***

FRONTERA GROUP

AT FRONTERA GROUP, WE CARE ABOUT HEALTH INEQUALITIES.

We wanted to research the drivers of the gender healthcare gap and what can be done to narrow it.

We surveyed 200 women* who had been diagnosed with a chronic disease and have seen a doctor **within the last 12 months.**

*The most common chronic conditions were diabetes (14%), arthritis (13%) and Crohn's (9%). Most of the women surveyed have had their chronic disease for a long time, with an average of just under 12 years.

MIND THE GAP

Research has repeatedly shown that a gender gap exists between the quality of healthcare that women receive, versus men. It exists in many countries, including the UK.[1,2,3]

The gap means that women can experience:

- Delays in diagnosis
- Delays in getting treatment
- Less accurate health information & poorer medical advice
- Fragmented healthcare services
- Worse disease management overall

This has a negative impact on health outcomes for women.

Delays in diagnosis mean that **half of the population is not getting the treatment they need, when they need it.** Women also have difficulty accessing care services, contributing to less testing and treatment, impacting health outcomes as a result.

There is a consensus among researchers that more evidence and data is needed on the quality of women's healthcare, specifically:

- Understanding determinants of women's experiences in the healthcare system
- Developing interventions to improve the health experience of women

PREVIOUS RESEARCH

In 2021, the UK Department for Health and Social Care (DHSC) launched **'Women's Health – Let's talk about it' survey** to inform the first-ever government-led Women's Health Strategy. Nearly 100,000 women shared their views and experiences.[1,2]

Only 3 in 5 women felt comfortable when discussing mental health conditions (59%). More than 4 in 5 women (84%) had experienced instances were they didn't feel listened to by healthcare professionals.

Specifically:

- Symptoms were not taken seriously or dismissed
- They had to persistently advocate for themselves to secure a diagnosis, often over multiple visits, months and years
- If they did secure a diagnosis, there were limited opportunities to discuss or ask questions about treatment options and their preferences were often ignored

Only 2 in 5 women said the services they needed we local / convenient.
1 in 4 said the same about having timely access to services when needed (24%).
The results were consistent with the 2019 'Better for women' UK report.[3]

> **"After waiting close to 4 months for an initial appointment with a gynaecologist (female) she told me it was probably in my head and dismissed my questions about possible endometriosis. She had told me to come back in a year."**

RESEARCH FINDINGS

We wanted to understand the factors that might be influencing a woman's experience of care.

We focused on the doctor–patient dynamic, exploring communication and the interpersonal processes that are **essential to relationship-centred care.**

INVESTIGATING DIAGNOSIS

The average time to diagnosis was 2.3 years. But there was a range, often varying by diagnosis:

- Metabolic diseases, such as diabetes, diagnosis took about 8 months
- For Crohn's and other autoimmune diseases, it was about 2 years
- Women with endometriosis had to wait an average of 10 years for a diagnosis

For some diseases, this makes sense as numerous tests can be required, inevitably taking time. What's interesting is that 60% of the women surveyed believed that their diagnosis took longer than it should have. A quarter of women reported **seeing 5 or more doctors before a diagnosis was made.**

But it wasn't just diagnosis that was perceived as a struggle.

Most women found **access to healthcare services difficult (60%).** Although all of the women surveyed were UK-based and so the NHS would have been their initial access point to care, about 40% felt they **needed to use private healthcare to get the care they needed.**

> **“...there's a lack of facilities to see a GP or specialist. I have now purchased private health care for my son and I'm considering it for myself - but it's very costly due to my condition.”**

STIGMA IMPACTS DIAGNOSIS & ACCESS

We wanted to understand the factors that might be influencing a woman's experience of care. We focused on the doctor–patient dynamic, exploring communication and the interpersonal processes that are essential to relationship-centred care. It is also where we, as behavioural science researchers, and our clients could have the most impact.

Starting with stigma.
Stigma occurs when people are stereotyped or discriminated against based on one or more of their attributes. Women who perceive this type of experience when interacting with their doctor may stop seeking care. They can feel increased stress about their health, impacting their self-esteem and motivation. Ultimately, they feel undermined in their ability to receive quality healthcare.[4]

The majority of women who said they were stigmatised said that they felt **discriminated against for being a woman (74%; see figure 1).** This primarily meant feeling that they were not being listened to or taken seriously.

Women who felt stigmatised by their doctor reported a longer time to get their diagnosis and confirmed difficulties in accessing the services they needed. This included getting treatment.[5]

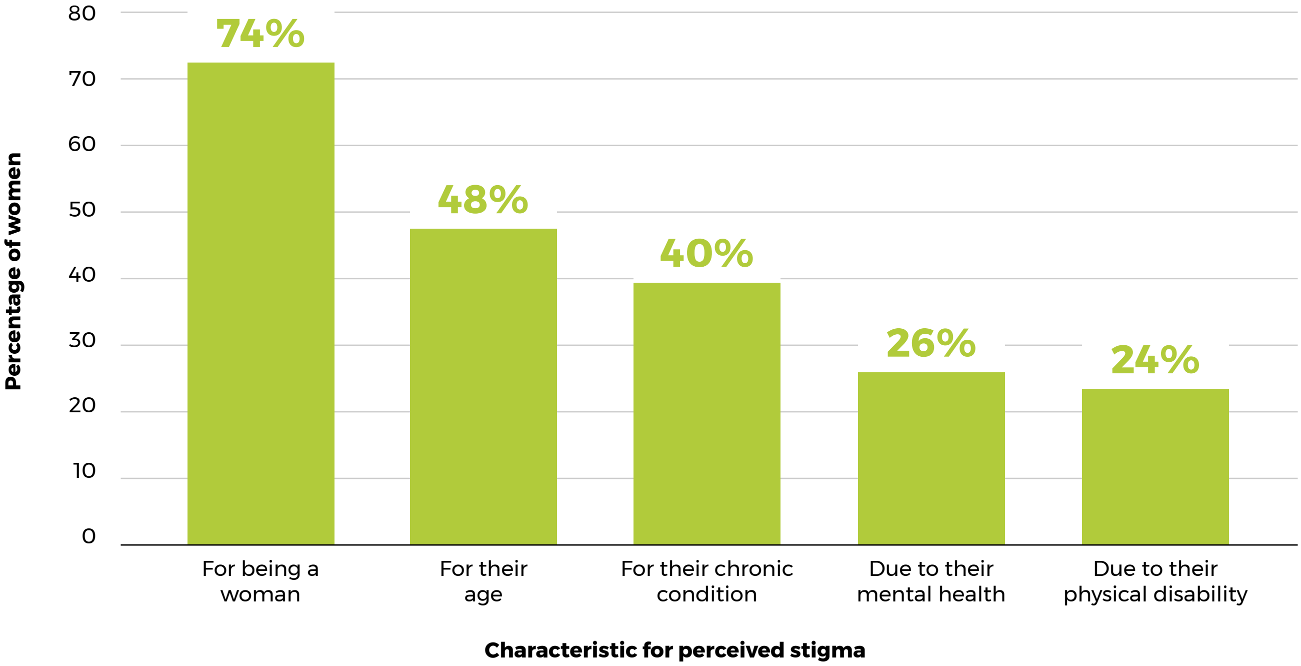

Figure 1. Of those stigmatised, most women perceived stigma/discrimination toward their gender more than other characteristics.

> Being spoken down to like a child, I assume because I am a young woman. It made me feel like I wasn't being listened to.

POWER OF THE DOCTOR–PATIENT RELATIONSHIP

So, stigma leads to delays in diagnosis and impairs access to healthcare services. But, if care is to be patient-centric, then we need to better understand the doctor–patient relationship (and the role of the patient in it).

In this context, doctor–patient communication is important, because good communication is expected to lead to improved patient outcomes. If this is to happen, then the patient needs to be an active participant in their own health. They also need to perceive the doctor as supportive of their involvement.

Encouragingly, **75% of women reported being actively involved. 57% of women also said that they had a supportive relationship with their doctor.**

The results show a clear relationship between stigma and both

- a woman's active involvement in their health, and
- perceived supportive relationship with their doctor.

HOWEVER
Women who felt stigmatised felt less empowered or in control of their healthcare.

Those women also had a worse relationship with their doctor. Common sense prevails here – it's good to be an active player in your own health, and no good comes from having a bad relationship with your doctor.

> **“I wish doctors would be our partners in helping us, working as a team. I feel there is a divide between patient and doctor.”**

MAPPING HOW FACTORS INTERACT

The final piece of the puzzle was to work out how all these different factors interconnect.

Using a statistical model that revealed what impacts what, we established that feeling stigmatised leads to an unsupportive doctor–patient relationship, i.e. one that does not empower patients.

It is this damaged doctor–patient relationship which directly causes:

- Delays to achieving / obtaining a diagnosis, and
- Delays to accessing much needed healthcare services, such as treatment.

INTERVENTION TECHNIQUES

Identifying the different factors involved, and unpicking how they impact each other, is essential if we are to design interventions that can close the gender gap and improve health outcomes for women.

Crucially, interventions must address the underlying drivers of stigma and the **influences that lead to an unsupportive doctor–patient relationship.**

DESIGNING INTERVENTIONS

Identifying the different factors involved, and unpicking how they impact each other, is essential if we are to design interventions that can close the gender gap and improve health outcomes for women.

Crucially, interventions must address the underlying drivers of stigma and the influences that lead to an unsupportive doctor–patient relationship.

Interventions that encourage doctors to create supportive relationships can also decrease stigmatising attitudes. For example, encouraging doctors to confront their own biases and correct their beliefs about women as patients (conscious and unconscious).

This does not mean that we should stop encouraging women to take an active role in their healthcare. Women who feel informed and confident are more likely to reach out to seek help and to take their medication as prescribed.

Patient activation through well designed patient support programmes (PSPs) is a key link in the chain that leads to positive health outcomes (see below for more information on patient activation and how PSPs fit in). But, as we see from the above analysis, patient activation can only do so much. Unless it can positively influence the doctor–patient relationship, it is may have limited ability to accelerate time to diagnosis in women.

> **“There is 100% a gender health gap. Womens conditions and treatments are poor, under researched and women are stigmatised. Times need to change especially for my daughters future...”**

SUPPORTING THE DOCTOR-PATIENT RELATIONSHIP

A relationship where the doctor enables the patient to feel in control of their own decisions has been shown to have positive benefits, including increased motivation (which might mean greater patient activation) and greater overall wellbeing.[6] This kind of relationship is known as 'autonomy-supportive'. It can be created by:

SUPPORTING PATIENTS' CHOICES

Allowing people to have a choice in important decisions creates feelings of empowerment and buy-in, which makes it more likely that they will attend appointments and comply with treatments.

RECOGNISING THE PATIENTS' PERSPECTIVE

Feeling understood is a vital component of empathy. When someone feels their perspective is being taken, it improves relationship quality, including increasing feelings of trust.

APPRECIATING THE PATIENTS' EMOTIONS

Related to feeling understood and empathy, appreciating and validating people's emotions further strengthens the relationship.

MINIMISING CONTROL AND JUDGEMENT

A quick way to thwart a person's autonomy is through controlling or judgemental language, such as using shame. While this can influence a person's behaviour, it is less effective and less likely to last long term.

PROVIDING A RATIONALE FOR ADVICE GIVEN

When patients understand and believe in certain necessary behaviours, they will want to engage in the behaviour.

PATIENT EMPOWERMENT

Patients that are actively involved in their healthcare are known as 'activated'. They have the knowledge, skills, and confidence to manage their own health.

Patient activation can be increased by empowering patients to take control of their health, but this is easier said than done. The best approach is through a patient support programme or PSP (usually specific to a disease area or type). PSPs provide education resources and motivational support to enable and encourage patients to be active players in their health.

To understand more about what makes a successful PSP, read:
https://frontera-group.com/wp-content/uploads/2023/02/FronteraBranding_Branded_Article_PSP_v1_FINAL.pdf .

IN CONCLUSION

The gender gap in health is well documented. But this survey has shone a light on the factors that underpin the frustration and disappointment that so many women feel.

Identifying the drivers (and barriers) involved can better inform the ways to tackle the problem and improve the quality of healthcare for women – and, ultimately, **close the gap and improve outcomes.**

Our sample consisted of 200 women in the UK who have been previously diagnosed with a chronic disease and have seen a doctor or specialist within the last 12 months. We collected a sample representative of the UK population with ages ranging from 18 to 74 (an average age of 47) and 85% of the sample white British (compared to 82% in the UK).[7] Socioeconomic status also ranged from below 30k (43%) to above 50k (26%).

WORK WITH US

We are experts in applied behavioural science. It's what we specialise in at Frontera Group. If you'd like to know more about the work we do, get in touch.

If you have a healthcare challenge that involves the health of women, or you want to improve outcomes and achieve growth by better understanding what drives the underlying behaviour of those involved, then we'd like to speak to you.

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