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Narrative Review of Gender Inequities in Healthcare

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ABSTRACT

Gender inequities in healthcare remain a persistent and under-examined global challenge despite decades of advocacy and policy commitments to gender equality. This narrative review synthesizes contemporary evidence on the multidimensional manifestations of gender inequity across access to care, quality of services, health outcomes, and healthcare workforce dynamics. It highlights persistent conceptual ambiguities surrounding sex and gender and underscores the importance of examining gender as a relational and intersectional construct shaped by sociocultural norms, economic structures, and power hierarchies. Findings reveal that gender influences health-seeking behaviors, exposure to risk factors, responsiveness of health systems, and intra-household decision-making, producing uneven patterns of morbidity and mortality between women, men, and gender-diverse individuals. Evidence from multiple settings indicates that women experience lower quality of care for several chronic conditions, while men underutilize preventive and primary health services due to gendered norms. Structural inequalities in the health workforce, including occupational segregation and gendered constraints on leadership opportunities, further reinforce disparities. Intersectional identities, including race, socioeconomic status, age, and migration background, exacerbate vulnerability and shape differential access to care. While numerous policies and interventions promote gender equity, gaps persist in the implementation, evaluation, and integration of gender perspectives into health systems. Methodological challenges, including gender bias, poor sex-disaggregated data, and weak operational definitions of gender, remain barriers to progress. Overall, the review emphasizes the urgent need to strengthen gender-sensitive health research, expand intersectional policy frameworks, and transform health systems through equitable, gender-responsive approaches.

Keywords: Gender Inequity, Health Systems, Intersectionality, Access to Healthcare, and Gender-Sensitive Research.

INTRODUCTION

The gender perspective in health, health care, and social determinants of health remains a neglected field, despite concerted calls to promote the health of women and men [1]. The COVID-19 pandemic and the perception of health equity as an area of significant concern have awakened interest in assessing the interplay of various factors, including socio-economic status (SES), education, ethno-racial determinants, and gendered dynamics. The contemporary literature acknowledges that gendered determinants of health remain poorly understood and inadequately documented compared to other dimensions. The existence of gender inequities in health and health care is established across the globe [5]. The World Health Organization's Health Organisation of the Americas, for example, reports that women are less likely to benefit from life-saving interventions in a pandemic. Gender-based barriers to health-care access were cited among the guiding principles to mitigate the epidemic's impact on vulnerable groups [6]. The viability of gender and health as a distinct area of scientific inquiry now appears to be firmly established.

Conceptual Foundations of Gender and Health

Health concerns may arise when patients face inequities in healthcare and other social determinants. Gender of patients is one consideration that can influence the quality of care and health status, but gender inequities in health remain poorly addressed [2]. The present review examines barriers to accessing healthcare by gender, the

gendering of care quality within institutions and societal settings, the gendered dynamics of supply-side actors, how intersections with race, ethnicity, and socioeconomic status co-shape gender inequities, and past and ongoing institutional efforts to understand and mitigate such disparities [3]. Around the world, definitions, frameworks, and methods continue to evolve regarding basic terms such as gender and sex, as well as the multi-dimensional factors and circumstances associated with gender and health. Gender and sex refer to a spectrum of attributes, associated roles, and social constructions related to being female or male that intertwine with biological factors. Gender refers to social constructions, societal expectations, and systemic influences from norms to power and privilege regarding opportunities, behaviours, and interactions [12]. Gender health refers to health outcomes or health disparities assigned a gender dimension, including socio-historical and socio-economic considerations that delineate roles, opportunities, or autonomy by gender. Gender inequities in health occur through disparate experiences, interactions, or access [9]. Sex denotes a two-category system, whereas gender extends into a wider spectrum. Gender socialization continues to produce hardening divisions between female and male identities, roles, and stereotypes that can restrict personal opportunities [8].

Access to Care: Barriers and Facilitators by Gender

Research has documented gender differences in access to care for sexually transmitted infections (STIs) and vaccine uptake for human papillomavirus (HPV) among adolescents, and voted informally that these differences constituted a barrier to healthcare service access [6]. A numeric GSC score computed from responses collected through an online survey of teenagers in the United States indicated that male adolescents exhibited greater inequalities in healthcare service accessibility across different health issues and/or healthcare service types compared with female adolescents [4]. Gender-based discrimination continues to shape health-seeking behaviors in everyday practices [7]. Men's higher participation rates in quantifying their own health information are limited to a relatively narrow set of health issues, reinforcing the notion that they deserve less comprehensive health coverage for both informational and access needs. Consequently, men remain hesitant to seek medical attention until reaching extreme stages of deteriorating health or having adverse medical events. Women are therefore viewed as the dominant gender in the capacity to access healthcare services to obtain health information [5].

Quality of Care and Outcomes across Genders

Gender-based inequalities in healthcare quality and outcomes often reflect socially constructed roles, behavioral expectations, and the perception of risk [1]. Women experience a lower quality of care than men for acute coronary syndrome (ACS), diabetes, and hypertension in both community settings and general acute hospital admissions 6. Gender disparity also exists in primary clinical care, health information services, pain management, and emergency care. Concerning health outcomes, adverse events, incidents, and healthcare-associated infections occur more frequently in female patients than in males, with women constituting the risk population according to French health authorities [1]. Although women report poorer health outcomes than men, international health organizations may disregard gender as a stratification variable in their databases, suppressing visibility for women's multimorbidity. Women continue to have higher life expectancies and lower mortality rates than men across all regions and levels of socio-economic development [5]. However, for pathologies that affect both men and women, women are both underrepresented in clinical studies and are inappropriate for their gender in emerging processing engine AI. Gender determinants influence differential access to healthcare, usage of services, and exposure to conventional risk factors, disease incidence, and health outcomes, with striking divergences still being observed in many societies and areas [7].

Moreover, gender remains a notable factor in intra-household bargaining power, its importance changing throughout an individual's life cycle and significantly conditioning post-divorce conditions in households with children [5].

Workforce Dynamics and Gendered Roles in Healthcare

Globally, gender stratifications create distinctive roles and expectations shaped by sociocultural circumstances, religion, ethnicity, education, and economic factors for women and men in society [7]. Gender influences health-related behaviors for both sexes and critically determines access to education, nutrition, and healthcare; yet gender remains an under-investigated dimension of health [8]. Some health domains, including the health workforce, are highly gendered, which potentially constrains access to education, training, and career advancement. Gender roles also influence broader behaviors (for example, physical activity, diet, drug use, and health-seeking behaviors), in turn introducing sex differentials into exposure to various health determinants while ladling distinct health risks upon women and men [8]. The prevailing gendered division of labor (paid and unpaid) proprioceptively constrains opportunity time to engage in multiple activities beyond the dominant roles associated with one's sex [10]. Women globally continue to dominate lower-paid jobs in health-service delivery (nursing, community health work, child health, etc.), whereas men frequently fill managerial, supervisory, and technical positions, affecting access to professional training and leadership roles [10]. Gender dynamics actively shape health-service delivery.

The substantial role of gender should be systematically recognised, making it possible to establish whether it affects the flow of health determinants [9].

Intersectionality, Gender with Race, Socioeconomic Status, and Other Axes

Though similarities in women's and men's health challenges arise, gender disaggregation remains critical. Further, the feminist agenda must expand to embrace women's multiplicity and move toward an ethic of care [10]. Each woman's identity is constructed at the intersection of various axes, such as ethnicity, race, age, socioeconomic status, immigration status, and sexuality, that together produce specific health risks and barriers. The health dimension focuses on race, ethnicity, and socioeconomic status [10].

Policy and Intervention Approaches to Reduce Inequities

Policies and interventions have been important before and during the establishment of health systems; such measures play an important role in society by providing people with opportunities and certain advantages. The awareness of policies targeting gender equity and strategies to reduce gender-related gaps is increasing. Therefore, the study of policies and interventions and the mapping of strategies needs to continuously advance to shed light on current issues and scientifically inform and guide practices [11]. Gender norms, patriarchal societal structures, and poverty limit women's choices in households and the health sector. Gendered violence constitutes a significant health determinant: adolescent girls experience sexual violence in Liberia, while in Tanzania, women may face violence when perceived to have introduced HIV into marriage [12]. Gender-focused policy and intervention approaches should tackle power relations to transform inequitable health systems and consider both structural resilience and everyday health system performance. Gender perspectives in policy are essential because the health system itself constitutes one of the main sources of gender-based inequality [13]. Despite significant international agreements and national policy attention since the 1990s, gender inequity in health persists. Elimination of child marriage and female genital mutilation and increased representation of women in political and managerial roles have been accomplished, and a toolkit of guides, indicators, and checklists to support policy implementation has been developed [10]. However, health systems remain key architects of health inequalities, and the gender perspective is infrequently addressed in health. Although numerous evaluations of health-related gender policies and analyses of strategies for increasing gender equity have been conducted, these two subjects have rarely been examined in tandem [11]. Policy and interventions are not classically defined as a theme of gender and health, and examination of the gender perspective in the definition of these subjects is scarce. Consideration of either element, however, often warrants simultaneous treatment. Approaches flow with the establishment of policies and with the policies themselves. In certain contexts, interventions are regarded as limited to the health sector but may extend well beyond it [13]. Measures characterized as policies and interventions accompany the introduction of a health system. Aware of the rise in attention to gender-oriented instruments since the 1990s, the purpose here is to review selected measures or tools and their scientific underpinning from the gender and health perspective. The larger objective is to foster an understanding of health policy and intervention, clarify the definition of intervention, and stimulate dissemination of relevant approaches [10].

Methodological Considerations in Gender-Related Health Research

When exploring health systems and access to health services, the differential impact of sex (biological) and gender (sociocultural) on health and health care must be considered [2]. Gender-sensitive health research is required to understand such impacts, yet methodological issues complicate this research. Gender bias, defined as the systematic over- or underrepresentation of men or women in health care, is particularly salient. Gender bias manifests in the allocation of health resources, health care delivery processes, high-level decision-making, and health-seeking behaviours [14]. Only 6% of gender-sensitive policies and 5% of policies to reduce gender inequalities in health are addressed at individual and institutional levels [13]. Fundamental, yet frequently overlooked methodological issues arise when conducting gender-sensitive health research. Gender must be explicitly defined, and research questions and objectives must specify why gender is relevant to the questions being addressed. Gender is best understood as a relational concept, and the relational nature of gender should be understood when selecting indicators, sampling strategies, data collection, and analysis methods. Gender relations, whether between individuals of the opposite sex or in same-sex relationships, must inform and be incorporated into gender-sensitive health research methodologies [11]. The relational nature of gender comprises three interlocking dimensions: personal (individuals' representations, identities, expectations, and behaviours), sociocultural (social frameworks and norms that shape individual constructions of gender), and institutional (formalised organisations and structures that mediate both personal and sociocultural expressions of gender).

Discussion

Healthcare systems across the globe continue to manifest gender inequities that compromise the central missions of health, fairness, and respect for individuals. Gender inequities in healthcare [12] mean systematic differences across genders affect health and wellbeing, access to and quality of services, health outcomes, and healthcare

workforce dynamics. The interaction of gender with additional dimensions of inequity, including race, ethnicity, socioeconomic status, and geography, deepens disadvantage for many groups [14-17]. Redress of gender inequity thus receives worldwide commitment across the public and private sectors, humanitarian organizations, and civil society [9]. Gender-sensitive and sex-disaggregated data increasingly supply needed evidence; however, persistent methodological weaknesses, gaps in knowledge, and conceptual ambiguities jeopardize progress [18-20].

CONCLUSION

Gender inequities in healthcare continue to represent a profound and deeply rooted barrier to achieving global health equity, quality of care, and universal health coverage. This review demonstrates that gender differences in access, care quality, health outcomes, and workforce participation are not merely biological phenomena but the result of persistent social, cultural, and institutional structures that shape opportunities, choices, and interactions across the life course. Women's experiences of poorer quality of care for certain conditions, men's lower levels of preventive health-seeking, and the gendered division of labour within the health workforce reflect a complex system where gender norms and power dynamics influence both service delivery and health outcomes. Intersectionality further compounds these inequities: individuals who experience disadvantage based on race, socioeconomic status, ethnicity, age, disability, or immigration status face amplified barriers and health risks. Although international frameworks and national policies have increasingly recognized the importance of gender equity, the integration of gender perspectives into health systems remains inconsistent and inadequately monitored. Existing interventions often fail to address underlying social norms or structural determinants, limiting their impact. To advance meaningful progress, health systems must adopt holistic, gender-transformative approaches that actively challenge inequitable norms, improve representation and leadership opportunities for women, strengthen protection from gender-based violence, and ensure that health policies are grounded in robust gender-sensitive evidence. Methodological improvements, including clear definitions of gender, relational analysis, and systematic collection of sex- and gender-disaggregated data, are essential for understanding the complexities of inequity and guiding effective interventions. Ultimately, addressing gender inequities in healthcare requires sustained political commitment, multisectoral collaboration, and continuous engagement with communities. By integrating gender as a foundational lens in health policy, research, and practice, societies can move closer to building inclusive, equitable, and resilient health systems capable of meeting the needs of all populations.

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