
EDITORIAL

Gender issues: Do as I say, not as I do?

In this issue of the *Journal*, Panteli et al. (6) provide insight into the extent to which a gender-sensitive approach is adopted by sixty health technology assessment (HTA) agencies worldwide. Their findings should make all of us involved in the production of HTA take pause: less than a handful of the agency Web sites that were examined by Panteli's team made any mention of gender as an explicit consideration in priority setting processes or in the HTA methods used (6). This is despite the fact that gender is recognized as a social determinant of health (1) and despite best practices that acknowledge the need to account for equity issues—of which gender is one—in the design, conduct, and reporting of HTA (3;4). Assuming we take the findings of Panteli et al. at face value, this does seem to be a case of “do as I say, not as I do.”

Admittedly, the work of Panteli's team could be more comprehensive; only the Web sites of HTA agencies were consulted so whether these agencies' Web sites were current and reflective of actual agency practice could be open to debate. A more thorough approach would have been to contact key individuals within each agency to validate the Web site's information or to identify an appropriate sample of HTA reports to determine the extent to which a gender-sensitive approach was applied. This, of course, takes time. In addition, in 2011, there is really no excuse for these agencies' Web sites to not accurately reflect current practices and approaches. So, although this reliance on Web sites may have contributed to a degree of uncertainty surrounding the precise prevalence of gender-sensitive approaches among this sample of HTA agencies, I would suggest that Panteli's conclusions are not too far off the mark.

So why is this the case? I think I can safely say there is general agreement for what should be examined in an HTA, and an appreciation for why. The fact that HTA studies the clinical, economic, social, ethical, and broader implications of the development, diffusion, and use of a health technology is what makes HTA so inherently valuable to decision makers

(5). If we, as HTA producers, didn't believe this to be the case, I doubt we'd be working in this field. On more than one level, a gender-sensitive approach to HTA makes complete sense. Such an approach speaks not only to the oft ignored issues of equity but also to the very foundation of HTA: does this technology work, for whom, and under what circumstances. So, this again begs the question: Why are we not paying attention to the issues that define HTA? Why are we not following the guidance that we prepared for ourselves? How many studies need to be published, shaming us for ignoring the non-clinical and non-economic implications related to the adoption of a health technology (2)? What will it take for us to “do as I say and as I do?”

Most of us will agree that an absence of evidence as to gender-sensitive approaches is not to be viewed as evidence of absence of such sensitivity. We would be hard pressed to find evidence in support of any overt activity to discourage, or actively ignore, a gender-sensitive approach. Instead, I suspect the realities of supporting informed decisions in our health care systems have contributed to what might be viewed as a *laissez-faire* attitude toward the non-clinical, non-economic (i.e., non-quantitative) components of HTA.

What might these realities be? There is the demand for faster HTA, meaning some components of traditional HTA may be dropped to enable the provision of at least “some” evidence to inform a decision, in a time frame that can be shorter than it would take to perform a comprehensive HTA. There is a body of literature documenting the sub-optimal reporting of the results of primary research; these deficiencies in reporting can preclude our ability to synthesize—across multiple studies—data by gender and other important variables that may have an influence on HTA findings. There may also be a level of uncertainty as to how to best handle the complexities inherent in examining ethical issues: who should do this, what kind of evidence is used, and how does it fit with the other, more quantitative components of HTA.

In addition, there may be apprehension as to the potential impact that can be made by adopting a gender-sensitive approach to both priority setting and the conduct and reporting of HTAs; put another way, there may be some ambivalence as to the “return on investment.” Although these factors may transpire to make it more challenging to adopt a gender-sensitive approach to HTA, they are insufficient justification for the discipline to abandon such an approach.

Indeed, the devil’s advocate might question whether HTA producers are doing a disservice to the health systems for which we work—and the citizens served by such health systems—when we provide only some pieces of the puzzle rather than the “big picture” that HTA can and should provide. We should thank Panteli and colleagues for noting how poorly we, as HTA producers, fare when it comes to approaching our HTA work with a gender-sensitive lens. We should view this wake-up call as an opportunity. Some things, such as following through on a collective commitment to increased transparency of our respective priority setting and HTA processes, are easily done. Other aspects, such as consistent application of a gender-sensitive approach to these processes may be more difficult; however, we need not start from scratch given that there are established approaches for incorporating this approach into synthesis work (3;7). Let’s not forget what HTA can and should be. Let’s commit to getting to the point where we “do as we say, and as we do.”

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CONFLICT OF INTEREST

The author reports she has no potential conflicts of interest.

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