Addressing Gender Disparities in Cardiovascular Disease: A Comparative Policy Analysis of Policy Initiatives in Healthcare Systems of the Netherlands and England

Vrij, Manouk

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Universiteit Leiden

Student: Manouk Vrij (s3198251)

Supervisor: Dr. ir. A.A.H.E. van Reuler

Leiden University

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1. Introduction

Gender is a prominent cause of health inequalities within contemporary medicine. Women often face inequality and inherent biases in healthcare, which potentially lead to delayed diagnoses, inadequate pain management, misdiagnoses, and even premature discharges during critical medical events (Merone, Tsey, Russell & Nagle, 2022, p. 49). The gender gap in medical research, in combination with misogyny perceptions, female underrepresentation in medical literature, and gender bias, bring disadvantages for female patients (Merone et al., 2022, p. 49). The persistent barriers to the impact of sex and gender on health prevent gender equality in the field have great repercussions, as, according to Peters and Woodward (2022), gender equality in health has been shown to improve the health of both women and men at the population level (p. 994). Therefore, it is important to take gender bias, the unintended but systematic neglect of either women or men, into consideration in the fields of health education, clinical practice, and medical research (Hamberg, 2008, pp. 237, 242).

This gendered inequality has been detected in multiple (chronicle/non-communicable) diseases, cardiovascular disease being one of them. Even though cardiovascular disease is worldwide a leading cause of death for both men and women, for women, in comparison to men, the disease is often under-recognised and undertreated in both primary (prevention focussing on avoiding the disease entirely) and secondary (prevention involving the screening of patients for early detection and diagnosis) preventative health settings. Psychological risk factors such as depression, stress and social determinants of health may disproportionately impact women as opposed to men, additionally unique female-specific risk factors such as adverse pregnancy outcomes, low oestrogen states, premature menopause, and chronic autoimmune inflammatory disorders may contribute to an increased cardiovascular disease risk in women (Metha et al., 2022, p. 1). Despite a steadily increasing focus on sex-specific data, this data it is not yet routinely collected nor translated into practice and studies investigating the impact of gender-related characteristics, and the onset of cardiovascular disease remain scarce (Jiménez‑Quevedo et al., 2023, pp. 338-339; Peters & Woodward, 2022, p. 994). As a matter of fact, recent research into healthcare disparities in cardiovascular medicine has shown that women have disparate treatment and/or experience worse outcomes of different forms of cardiovascular disease (Fishkin et al., 2022, p. 1).

Healthcare systems have been institutionalised to provide healthcare for those who are in need of it, therefore providing security against major life risks. However, these systems are dynamic and adaptive through the constant interplay of various stakeholders, regulatory frameworks and institutional arrangements. Therefore, healthcare systems may vary in structure and method of performing (Wendt, 2009, pp. 432-433). Furthermore, as gender disparities shape health experiences and affect the ability of healthcare systems to respond, these systems play a crucial role in the pursuit of gender equality within health (Theobald et al., 2017, p 2). However, in current academic health scholarship, little research has focused on how gender disparities diverge in different sorts of healthcare systems. By examining the role of policy initiatives addressing gender disparities in cardiovascular disease treatment in healthcare systems, this thesis aims to identify how different healthcare systems act in order to reduce gender disparities (Hay et al., 2019, p. 3). Therefore, the academic relevance of this research is the contribution to the field of health policy analysis through the presentation of a comparative perspective from the policy side of gender disparity in cardiovascular disease in healthcare systems. In addition, for societal relevance, by creating an understanding of how policy initiatives address gender disparities in cardiovascular disease, it may highlight the current gaps of knowledge regarding gender disparity of health providers in healthcare provision, which is crucial for improving health equity from within the system.

This thesis will start by reviewing the existing literature on gender disparities in medical research, the gender disparity of cardiovascular disease in medical research, healthcare systems and health policies, which will identify the gap in the literature and eventually lead to a research question (*Ch. 2*). Further, a theoretical framework will be established, in which the theory, concepts, and theoretical background and expectations will be thoroughly discussed (*Ch. 3*). In order to conduct the research, the research methods, case and data selection will be mentioned, and the variables operationalised (*Ch. 4*). Then, the results will be introduced, followed by a discussion and reflection of the main findings (*Ch. 5*). Finally, in the last section, the conclusion will answer the research questions and discuss the limitations of this research and provide recommendations for prospective research (*Ch. 6*).

2. Literature Review

Academic scholarship has found the neglect of women in medical research to be reinforced by androcentrism. Former research from Merone, Tsey, Russell & Nagle (2022) supports this argument by stating that the research data collected from males has been subsequently generalised to females. In a different study, Merone, Tsey, Russell, Daltry & Nagle (2022) define this phenomenon as androcentrism, the assumption that all people are valued according to male standards. The authors argue that medicine is androcentric, as it not only assumes male bodies to be the norm but also regards male-dominant knowledge to be the most valid. However, the representation and participation of women in medical research is of the essence as medical research guides and it contributes to the development of clinical guidelines (Merone et al., 2022, pp. 49-50). Clinical guidelines directly impact the lives of patients, hence, the neglect of sex and gender differences in the clinical response hinders female health and androcentrism is thus deemed problematic (Merone et al., 2022, p. 56). Subsequently, the consequential lack of research evidence from female patients may result in a delay in treatment, withholding of effective treatments, or the appliance of inappropriate, ineffective, or harmful treatments, as inaccurate conclusions may be drawn on how women may respond to certain diseases. This phenomenon is further illustrated by the 'Yentl Syndrome', which outlines gender bias in the management of coronary heart disease as its medical research is predominantly studied and based on symptoms of heart attacks found in men (Ovseiko et al., 2016, p. 2). Ruiz-Cantero et al. (2001) argue that gender bias is related to a general social construct, referring to the way researchers conceive a study, the accuracy of results, and how these results are used to inform healthcare policymakers, healthcare, and (preventive) health promotion services (pp. 46-47). Thus, for this reason, the representation of women in (medical) research is deemed of the essence.

2.1 Healthcare systems

Academic literature has revealed that gender is often neglected in healthcare systems and that these healthcare systems are often not gender-neutral (Morgen et al., 2016, p. 1070). Morgen et al. (2016) argue that as gender influences how people interact dynamically in intricate, multi-faceted and context-specific ways, reflecting diverse values, interests, and power, it should be ingrained in health and healthcare systems research (p. 1070). Research by Percival et al. (2014), in like manner, discusses this matter and similarly finds the notion that

institutions (healthcare services) are not neutral (pp. 5-6). Furthermore, they suggest that, as these institutions reflect the social context in which they are situated, healthcare systems can therefore contribute to either gender inequalities or gender equality (Percival, et al, 2014, pp. 5-6). The influence of restrictive gender norms and inequalities, affecting the efficiency, strength, and health impact of the distinctive components and the healthcare system as a whole can therefore have a negative effect on the population. As gender inequality impacts health systems and the population they serve, the way healthcare services are structured and handle gender (in)equality thus influences the ability of these systems to achieve equal care for men and women (Hay et al., 2019, pp. 4, 23).

Additionally, Fishkin et al. (2022) argue that in cardiovascular medicine, healthcare disparities provide challenges for healthcare professionals and policy-makers in the aspiration for more equitable care, as these disparities are often unrecognised (p. 1). Subsequently, Mehta et al. (2022) make an argument for a multi-disciplinary approach, at educational, research, clinical, advocacy, and community levels, to achieve the equal provision of comprehensive care within health (p. 11). In addition, the appliance of gender analysis of healthcare systems contributes to the medical field, as it seeks to understand how gender power relations generate inequalities in the distribution of labour and roles, access to resources, decision-making, and social norms and values (Morgan et al., 2018, p. 2). By disrupting health systems from within, through economic and social policies, and community accountability mechanisms, Hay et al. (2019) hold that gender norms can be shifted and therefore inequality reduced (p. 23).

A study on the healthcare system responses to gender during the COVID-19 pandemic, which looked at the different kinds of healthcare systems of national health service (NHS), social health insurance system (SHI), and unified health system, found that all mentioned healthcare systems failed to protect women's health and essential public health targets. However, further findings from the research indicate that the NHS systems might provide better opportunities for integrating services relating to gender-based violence than the other types of systems in the study (Kuhlmann et al., 2023, pp. 1, 8). Numerous researches have been conducted looking into gender disparity in healthcare systems, yet the have often focused on healthcare systems in the broader sense and not discussing the differences between the different categories of healthcare systems, therefore limiting the comparative understanding of the

issue. Thus, research on how different categories of healthcare systems approach and manage gender disparity subsequently remains undiscovered.

2.2 Health policies

Academic scholarship has found that gender perspectives have challenged policy studies by revealing the lack of neutrality in policy making and its study (Lombardo, Meier & Verloo, 2017, p. 1). According to Lombardo, Meier, and Verloo (2017), androcentrism in policymaking indicates that processes and policies reinforce a male power advantage and that institutions are pervaded by a deeply embedded culture of masculinity (p. 5). Parrott (2002) has a similar perspective on this matter as he suggests that policies are structured with inherent biases that provide for advantage to some groups while disadvantaging others (p. 57). Key policy issues such as the lack of medical insurance for non-hormonal modes of treatment for menopause symptoms, lead to the discussion about the role that policy and government-funded research have on women and the implications of medical recommendations on women's health. As policy decisions filter and shape the dispersion and development of health knowledge, decision-making concerning treatment, and preventive practices, a gender-sensitive approach to the discussion on policy will open the debate on how gender and health are shaping policies (Parrott, 2002, pp. 59, 66). This is important, as healthcare policies shape the types of opportunities women have to receive effective primary and secondary prevention, management of diseases, and treatments for heart diseases (Brindis & Freund, 2008, p. 173).

In addition to that, Kouvari et al. (2020) argue that policymakers should address gender disparities in cardiovascular disease through the design, evaluation and delivery of sex and gender-specific guidelines and strategies to increase awareness, enhance research, and optimise disease diagnosis, treatment, and prevention (pp. 2079, 2090). They find that cardiovascular disease prevention and control has to be a collective effort by a combination of researchers, policy-makers, stakeholders, and healthcare systems (Kouvari et al., 2020, p. 2090). Payne (2009) presents a similar argument by calling for gender mainstreaming, gender impact assessment and gender-specific targets in policy-making to address and eliminate gender inequality (pp. 9-10). Gender mainstreaming aims to address gender explicitly in policy, by integrating gender impact assessment and gender analysis at all levels of policy through a systems approach. Gender impact assessment is defined as the (re)organisation,

development, improvement and evaluation of policy processes, which fosters the incorporation of a gender equality perspective in all policies at all stages and levels, by the actors commonly involved in the policy-making process. Lastly, gender-specific targets focus on issues relating to the perceived quality of care, at a local, regional, national, or collectively across all levels, as they are evolved through the healthcare system (Payne, 2009, pp. 9-10).

To recapitulate, both policies and healthcare systems (may) influence gender disparities in cardiovascular disease. However, limited research has been conducted on the role different types of healthcare systems have. Thus, this leads to the following research question that will be explored: How are policy initiatives aimed at reducing gender disparities in cardiovascular disease treatment designed and implemented across different healthcare systems?

3. Theoretical framework

3.1 Conceptualisation

3.1.1 Gender

The concept of gender is generally characterised as a societal construct referring to roles, behaviours, preferences, and activities. It is seen as a social identity shaped by social and cultural processes, describing an individual's social identity and personality traits, which may or may not be related to their biological sex (Blakeman, 2020, pp. 214-215). On the other hand, sex refers to physiological and biological characteristics defining humans as female, male, or intersex (Merone et al., 2022, p. 50). Gender and sex are often used interchangeably in research, which overlooks the divergent implications and unique variability and information of the distinct concepts. Gender encompasses the biological differences between males and females, and therefore allows for a broader insight into the way in which societal norms, experiences and roles contribute to disparities in healthcare systems and outcomes. Thus, for that reason, the term gender, instead of the term sex, will be used in this research.

3.1.2 Disparity in healthcare

The term disparity in healthcare is generally defined as a difference in treatment that is not justified by underlying health conditions of patients or preferred treatment choices by patients, and leads to differences in health outcomes and impacts access to quality care (McGuire et al., 2006, p. 1980; Iyanda, Boakye & Lu, 2001, p. 744). These disparities are socially produced, preventable, modifiable, and consequently unjust, and often stem from broader inequalities (Fishkin et al., 2022, p. 1). Moreover, when gender inequalities and restrictive gender norms are replicated and reinforced in healthcare systems, it contributes to and strengthens gender inequalities within health. Gender disparity therefore refers to the unequal treatment or opportunities between individuals based on their gender. Health equity, on the other hand, generally refers to the elimination of healthcare disparities, and all individuals achieving their highest health status possible (Fishkin et al., 2022, p. 1; Hay et al., 2019, p. 23). Policies and best practices can reinforce equity in health (Kouvari et al., 2020, p. 2080).

3.1.3 Healthcare systems

Healthcare systems are systems that provide healthcare services to a population through an integrated network of people, institutions, and resources, aiming to improve the health of the population and provide people with access to care (Afzal & Arshad, 2023, p. 1). Variations in healthcare systems stem from historical experiences, societal values, political systems and the availability of resources (Jaworzyńska, 2016, pp. 41-42). In healthcare scholarship, the categorisation of healthcare systems in different models has varied. Historically, the conceptualisation for the three main models of healthcare systems have been the Beveridge model, the Bismarck model and the private insurance model. Firstly, the Beveridge ‘public’ model is characterised by a centrally organised national health service, provided by public health providers and mainly funded by taxation. Secondly, the Bismark ‘mixed’ model is typified by a mix of private and public providers, and funded primarily by a premium-financed social/mandatory insurance. Lastly, in the 'private' insurance model providers are mostly found in the private sector, which makes this model predominantly privately funded, (Lameire, 1999, pp. 5-6; Or et al., 2010, pp. 72-73). However, in current scholarship the following concepts are prevalent: national health system, abbreviated to NHS with a system of universal coverage and financed by general taxation, and social health

insurance system, abbreviated to SHI with compulsory, universal coverage through non-profit insurance funds (Burau & Blank, 2006, p. 65). For the NHS, regulation, financing, and provision is done by the state, whereas for the SHI, regulation falls under the responsibility of the state, but the financing is societal, and provision is arranged by the private sector (Böhm et al., 2013, p. 260). Böhm et al. (2013) classify the NHS and SHI conceptualisation based on the existing healthcare system framework of Bismarck and Beveridge (p. 264). The traditional Bismarck and Beveridge distinction is more vast, leading to a more limited categorisation, whereas the NHS and SHI further allow for the inclusion of the regulative dimension (Böhm et al., 2013, p. 264). The latter classification of NHS and SHI thus provides a broader categorisation of healthcare systems, hence it can be applied to diverse healthcare systems.

The different models of healthcare systems are characterised and defined by the following typologies: supply, public-private mix, access regulation, primary care orientation, and performance. Supply refers to the level of resources in a healthcare system. Public-private mix examines the involvement and role of the state, societal actors, and the market. Access regulation defines the conditions under which individuals have access to care. Primary care orientation considers the importance of primary care for achieving health policy goals. Lastly, performance is defined as the extent to which systems attempt to achieve performance goals in the prevention and quality of care (Reiblin, Ariaans & Wendt, 2019, p. 613). For this research typology 'public-private' mix is the most relevant, as it analyses the role of the state, societal actors, and the market. As mentioned above, for NHS healthcare systems, the state is the main actor, and both societal actors and the market play a smaller role. Moreover, for SHI healthcare systems, the state, societal actors, and the market, all three have a different, more equal role, as regulator, provider, or financing actor (Böhm et al., 2013, p. 260).

3.1.4 Policy initiatives

Policy initiatives represent a deliberate effort in the form of strategic actions taken by governments or organisations to bring change or address a problem through policy action, generally within the framework of public policy (Guimón, 2019, p. 6; Lindquist, 2006, p. 313). These initiatives in the context of health are aimed at improving the governance of systems of healthcare systems, while being influenced by organisational context, resource mobilisation, and power dynamics (Hall & McGinty, 1997, p. 461; Or et al., 2010, p. 281).

Guimón (2019) categorises three main types of initiatives: those facilitating the transfer of knowledge, encouraging science-industry collaboration, and promoting research excellence (pp. 5-6). Looking through a political science lens, the facilitation of knowledge transfer will be the main focus of this thesis, as it entails the translation of research on gender-specific health issues and disparities into actionable policy interventions and recommendations (Guimón, 2019, p. 3).

3.1.5 Cardiovascular disease

Cardiovascular disease (CVD) encompasses all conditions that affect the heart and blood vessels, which impact blood circulation (Thiriet, 2029, pp. 2, 15). It refers to a range of problems, many of which relate to the build-up of plaque which narrows the arteries, making it harder for blood to flow. Common types of cardiovascular disease are heart attack, cardiac arrest, cerebrovascular disease, heart failure, coronary heart disease, atherosclerosis, and ischemic and hemorrhagic stroke (Tsao et al., 2022, p. 153). Within cardiovascular disease, there are gender-related differences due to differences in cardiac function and structure, sex hormones, and socio-psychological characteristics between males and females. This disparity calls for gender-specific prevention strategies, diagnosis, treatment, and prognosis in cardiovascular disease (Zhou & Bei, 2020, p. 1).

3.2 Theories

Within the current literature on gender disparity within healthcare systems, few theories are generally applied. However, the theory of health system governance would be a fit for this research. Health system governance involves the structure, processes, and actors responsible for decision-making and the implementation of policies within a health system. It provides insights into the dynamics of healthcare system performance, which may display the underlying institutional incentive problems (Brinkerhoff & Bossert, 2013, p. 685). Health system governance may show how governance arrangements within healthcare systems, such as the interactions and roles of regulatory bodies, governmental agencies, stakeholders, and healthcare providers, shape the development and implementation of policies that aim the address gender disparity within cardiovascular disease (Brinkerhoff & Bossert, 2013, pp. 686-687). Thus, the structure of a healthcare system, thus the type of healthcare system, influences how policies are designed and enforced. The actors involved in health system

governance have the responsibility or capacity to carry out health system functions such as delivering services, providing oversight, generating resources or exerting influence over decisions (Abimbola et al., 2014, p. 30). Abimbola et al. (2017) identify three different approaches in health system governance: (1) government-centred approach, focussing on the role of governments, (2) institutional approach, focussing on how rules governing economic and social interactions are made, monitored, changed, and enforced, and (3) building-block approach, emphasising the internal dynamics of healthcare organisations; viewing governance as one of the building blocks of organisations (p. 1336). The institutional approach would involve the examination of broader institutional frameworks, governance structures, and regulations that shape the design, implementation, and effectiveness of policy initiatives aimed at reducing gender disparities in cardiovascular disease, and thus will be the best fit for this research.

3.3 Theoretical background and expectations

Based on previously conducted research, the notion that the way healthcare systems are structured may influence their ability to provide equal care for men and women can be applied. Meaning that the type of healthcare system influences gender disparity in cardiovascular disease. The health system governance theory suggests that the structure of healthcare systems influences how policies are designed and implemented. The NHS has a tax-based healthcare system with the state as the main responsible actor in health, whereas the SHI has an insurance-based system with the state merely as an actor with a regulatory role (Or et al., 2010, p. 274). Or et al. (2010) further find that tax-based systems (NHS) are based on the principles of universality and equal access, while insurance-based systems (SHI) are based on more individualistic principles such as freedom of choice (pp. 278-279). These observations lead to the following two expectations.

First, for preventative policies on reducing gender disparity in cardiovascular disease, the NHS system is expected to have more comprehensive and uniform policies. With the state as the main actor in health, often a strong emphasis is put on public health initiatives and public-wide strategies. The principal actor role of the state may allow for a better possibility of large-scale implementation of preventative programs. For SHI systems, preventative policies may be less comprehensive and uniform, as health is provided by various private providers, which generally provide preventative services often designed to attract customers

(Or et al. 2010, pp. 278-279). Further, as these preventative services are provided by the individual (private providers), the government may produce less preventative policies. Thus, the state might encourage preventative care through incentives and regulations, but the primary implementation and emphasis may fall on private entities.

Second, for policies on the management of cardiovascular disease and reducing gender disparity within cardiovascular disease management, similarly to the prevention policies, the NHS is expected to provide more thorough policies. In like manner, the principal actor role of the state may allow for the coordination of policies for cardiovascular disease management. For SHI healthcare systems, due to their fragmented structure, may encounter difficulties in coordinating efforts for structural policies, due to the need for interactions between the regulating government and providing private parties.

4. Research methods

4.1 Methodology

To examine how policy initiatives are aimed to reduce gender disparities in cardiovascular disease within healthcare systems, a qualitative research will be conducted. Qualitative research methods allow for rich descriptions of phenomena that enhance the understanding of events and their context. In addition, qualitative methods can help identify configurations and patterns among variables and to make distinctions (Sofaer, 1999, p. 1102). Therefore, Sofaer (1999) argues that it not merely allows for description, but further moves inquiry towards more meaningful explanations (p. 1102). The qualitative method that will be employed is a comparative case study. This will allow for this phenomenon of political interest to be characterised through occurrences that are in common or dissimilar (Dion, 1998, p. 127). Additionally, Halperin & Heath (2012) argue that comparison allows for hypotheses to be generated and tested in order to explain variations, thus displaying the potential diverse approaches in the healthcare systems (p. 233). For this research small-n comparison study is employed, which allows for a more comprehensive and detailed in-depth analysis of both cases. Subsequently, this may provide for a greater scope for conceptualisation (Halperin & Heath, 2012, p. 238).

For the variable of gender disparities in cardiovascular disease policies, the presence and specificity of gender-specific guidelines and policies related to cardiovascular treatment within healthcare systems will be measured, by assessing the inclusion of gender-specific diagnostic criteria, risk factors, treatment protocols, and preventive measures in cardiovascular disease policy. For the analysis, the presence and relevance of gender disparities in policy initiatives on cardiovascular disease will be examined. When looking at the policy initiatives, the more gender differences in cardiovascular disease will be discussed, the more important the topic is deemed. Therefore, the absence of gender or gender differences in cardiovascular disease in these policy documents will be taken as no importance given to this topic. In order to understand how different healthcare systems design and implement policy initiatives to tackle gender disparities within cardiovascular disease, this research will analyse how comprehensive and detailed this is discussed in policy documents from countries with different healthcare. The comparative analysis between the two different healthcare systems, and thus examination of possible varying policy frameworks will allow for a deeper understanding of how policy initiatives aimed at reducing gender disparities in cardiovascular disease are implemented and designed. In the analysis, this means that the focus will be put on which country (and thus which healthcare system), provides the most comprehensive and detailed policy initiatives on gender disparities in cardiovascular disease. Subsequently, for processing the data, the cases of the Netherlands and England will first be individually discussed. This will involve a thorough examination of healthcare policies, which will highlight strategies employed. Then, following the individual analysis, the results from both cases will be compared.

4.2 Case selection

This thesis will be focused on countries in Europe. On an EU level, the European Society of Cardiology (ESC) and the European Heart Network (EHN) address the representation of women in cardiovascular disease in research and treatment through the EuroHeart project. In their most recent research on the topic of female representation in cardiovascular clinical trials, they found that despite an increase, women remain underrepresented, particularly in the field of ischaemic heart disease, heart failure, and cholesterol-lowering therapy (Stramba-Badiale, 2010, pp. 1677-1680). Through programs such as the EuroHeart Failure survey, the European Unified Registries for Heart Care Evaluation and Randomised Trials (EuroHeart) initiative, and MyHeart (system for prevention and monitoring of cardiovascular

diseases), which fall under the umbrella of the EuroHeart project, the EU aims to improve cardiovascular care (Cleland et al., 2000, p. 123; Batra et al., 2021, p. 162; Villalba et al., 2009, p. 1). Thus, the European Union is not directly concerned with domestic policy initiative processes, but moreover can be described as a monitoring and research facilitator. Therefore, as the European Union does not play an essential role in the creation or modification of policy initiatives, Brexit should not have a considerable effect.

As for the case selection, the Netherlands and England will be used in this research, as they present contrasting healthcare systems, social health insurance systems and national health systems. In order for a comparative case study to provide insight into a broader phenomenon, according to Gerring (2009), the selected cases must be representative of a broader set of cases (p. 649). In this research, the selected cases are the Netherlands and England. These countries present as representative cases for healthcare systems in Europe, as they exemplify the two major health system models, the national health system and social health insurance system, and encompass the key variations found across European health systems, publicly funded versus social insurance-based. The previously mentioned third category, the private insurance system, is not represented in this study, as most industrialised (European) countries have adopted social health insurance systems or national health (Tulchinsky & Varavikova, 2001, p. 623). Further, social health insurance systems and national healthcare systems generally retain more governmental interference and therefore can allow for a clearer analysis of how policy interventions translate into gender-equal health outcomes (Tulchinsky & Varavikova, 2001, pp. 625-626). Therefore, these cases provide valuable insights into how different healthcare system structures influence policy development and implementation regarding gender disparities in cardiovascular disease.

The Netherlands has a predominantly social insurance system (SHI) with universal coverage and regulated competition among insurance. It features a mixed-public-private healthcare system with mandatory health insurance for all citizens, with the government acting as a regulator of the system, ensuring universality and monitoring the quality of care, and private insurers serving as administrators and facilitators of health within this publicly regulated system. As the healthcare delivery is largely managed by private providers, the Dutch healthcare system has a decentralised character (den Exter & Guy, 2014, pp. 256-257, 261-262). The last major healthcare system reform of 2006 radically changed the roles of actors in the healthcare sector, as the reform introduced managed competition among actors

in healthcare. Within the SHI system, the whole population enjoys ‘basic health insurance’, covering essential curative care, and additionally, varying additional premiums are paid, which provide optional insurance coverage, including lifestyle programs. Therefore, cardiovascular disease prevention will be partly covered by taxation, partly by basic insurance, and partly by optional insurance coverage (lifestyle programs). Thus, some aspects of cardiovascular disease prevention are universally accessible through taxes and basic insurance, whereas other aspects are available through individual choices and optional insurance (Schäfer et al., 2010, pp. 13, 22-25)

England administers a publicly funded national health service system by the NHS (National Health Service) with universal coverage, providing comprehensive healthcare services which are free of charge at any point of use by patients. The National Health Service is a form of a unified health system. The healthcare system is centralised with the government being responsible for the majority of the funding and delivery of healthcare, with the majority of the funding coming from the government’s general taxation revenue (Peckham, 2014, pp. 154-155). The NHS is thus a tax-based healthcare system, with the state as the main actor (Or et al., 2010, p. 274). At the national level, the Department of Health and Social Care is responsible for health policies, strategies, as well as legislations and regulations for the NHS, and the finances. Supplementary to and working alongside the NHS, England also has a private healthcare sector for those who choose to access private healthcare. In 2022, around 12% of the population in the United Kingdom was additionally insured via the private sector, which takes a proportion of the workload away from the NHS (Law, 2022, pp. 1-2).

4.3 Data collection

As the research is focused on policy initiatives, policy documents on cardiovascular disease will be selected from the countries. The data that will be collected are relevant documents, including healthcare policy documents such as policy papers, legislation, governmental reports, and program evaluations. These documents will provide an understanding of the policy responses to cardiovascular disease and gender disparities in the Netherlands and England. These documents will fall under one of two categories: prevention or management of cardiovascular disease.

The timeframe which will be considered is from the year 2000 onwards (thus the year 2000 till the year 2024) as this timeframe presents the most relevant and current healthcare practices, also providing enough policy documents in order to conduct meaningful research. These policy documents will be looked for on governmental websites and websites from (governmental) health institutions and agencies for both countries, as these have generally well-kept online archives of policy documents, legislation, governmental reports, and program evaluations.

5. Case studies

In the following section, the findings from both England and the Netherlands will be presented. The policy documents are divided into the categories of preventative policy documents and management policy documents, which will both be discussed separately.

5.1 England

The following section will present and discuss the findings from the policy documents of England. This is divided into two subsections, policy documents on cardiovascular disease prevention and cardiovascular disease management.

5.1.1 Prevention

Overall, throughout the different preventative cardiovascular disease policies, gender is generally recognised as a significant risk for cardiovascular disease. However, specific initiatives on targeting these gender disparities are often lacking, as these policies do not move beyond rhetoric about the importance of measures for the inclusion of women. Therefore, leading to a persistent gap between stated intentions and the practical implementation of strategic measures. Additionally, as no clear timeline is provided, these preventative documents remain more aspirational and unsubstantiated commitments, outlining goals rather than concrete, actionable steps.

Further, some documents discuss the presence of inequality within cardiovascular disease but solely refer to initiatives aspiring to achieve equality as a whole, not specifying if equality for a certain subgroup is meant. In other instances, these preventative documents put an emphasis

on the need for universal access to preventative services, broadly indicating socio-economic inequalities, rather than gender-specific issues. When the focus is put on socio-economic inequalities, which may or may not include the inequality between genders, it is unclear whether gender disparity is taken into account. Therefore, gender disparities often may be subsumed under the larger umbrella of socio-economic inequality. Subsequently, cardiovascular disease prevention programs include gender considerations primarily in the context of broader health inequalities.

Thus, when gender disparity is mentioned in cardiovascular disease prevention policies, it remains rather aspirational with unsubstantiated commitments. When these documents do get more concrete, they generally refer to health equality as a whole, or subsumed under socio-economic inequality.

5.1.2 Management

In terms of cardiovascular disease management, policy documents tend to put an emphasis on equity within the service provision of cardiovascular disease and highlight the need for better diagnostic support, personalised care planning, and increased access to cardiac rehabilitation. However, apart from a sole health strategy which explicitly focuses on improving care and health outcomes for women, most policy documents acknowledge the broader health inequalities but often neglect to provide specific measures to address gender disparities within cardiovascular disease management. In these documents, gender will be typically mentioned as a non-modifiable risk factor, and therefore will rather be focusing on the broader health inequality concerns than on targeted gender interventions. Subsequently, similarly to prevention policy documents, cardiovascular disease management policies remain rather aspirational, lacking a concrete timeline or detailed implementation plan.

5.2 The Netherlands

The following section will present and discuss the findings from the policy documents of the Netherlands. This is divided into two subsections, policy documents on cardiovascular disease prevention and cardiovascular disease management.

5.2.1 Prevention

Predominantly, in the prevention policy documents of the Netherlands, the significance of lifestyle factors that reduce the risk of cardiovascular disease is highlighted. These policies generally provide concrete guidelines, mostly discussing nutritional requirements, alcohol usage, and smoking behaviour. Gender differences in nutritional needs are regarded and recommended dietary intakes for mitigating are formulated to address the unique differences between the genders. However, with the examination of different impacts of alcohol consumption on men and women, apart from specific mentions of pregnant women, the prevention approaches remain largely general and refrain from gender-specific measures.

Overall, most prevention policies emphasise the need for more gender-specific research which create better adaptable preventative measures. They highlight the limitations of current research, which is often predominantly based and includes men and press for the stratification of results by gender to improve the gender-specific applicability of guidelines.

5.2.2 Management

Policy documents of cardiovascular disease management generally acknowledge gender differences, attributing this disparity to systematic issues in healthcare delivery that disproportionately affect women, causing underdiagnosis and under-treatment. When these documents recognise these premises, they largely call for more focused research and personalised care of women. However, concrete and detailed strategies for addressing these disparities are lacking, leaving these policies to be rather ambitious than operational.

When gender inequality is not explicitly named, policy documents mostly refer to health equality as a whole, or on socio-economic health equality as a significant focus for action. In these instances, it remains rather unclear if gender is incorporated when ‘health equality’ and ‘socio-economic health equality’.

6. Analysis

The following section contains the examination of both preventative and management policy papers from the Netherlands and England. Firstly, the findings from the preventative policy papers from the Netherlands and England will be discussed altogether, whereafter the findings from the management policy papers from both countries will be considered collectively.

6.1 Prevention

In the cardiovascular disease prevention policies, both countries generally show awareness of gender disparity in cardiovascular disease policies, however, lack concrete policy initiatives and targeted actions to address these disparities. Overall, they neglect detailed and concrete plans and do not suppress the outlining of goals and ambitions. Further, for both the Netherlands and England, when preventative policies do not address gender disparity, they do mention either health inequality as a general concept or socio-economic inequality. In these instances it is unclear whether gender inequality is also a topic of concern or gender is just seen as a non-modifiable risk factor.

For the Netherlands, the preventative policy documents do provide more concrete differences between men and women, with a focus on nutrition, alcohol, and smoking behaviour. In the policies with nutrition as a focal point, a clear distinction is made between the needs of men and women. Thus, the way these policy initiatives are designed and structured is through the focus on nutrition, alcohol, and smoking behaviour guidelines. For England, these concrete differences are lacking, not moving further than shortly describing the differences in maximum alcohol intake for both men and women separately. Therefore, these policy initiatives are generally designed and structured through a focus on alcohol guidelines. For both countries, preventative policy papers do mention pregnant women as risk groups, but also neglect to provide more concrete plans that ‘has to be further researched’. Thus, for both countries, the design and structure of the preventative policy initiatives include the mentioning of women being underrepresented in cardiovascular disease, with both England and the Netherlands advocating for the betterment of the representation of women.

Comparing these two cases, the Netherlands, and thus the SHI system seems to have more detailed and comprehensive preventative policies regarding gender disparity than England, the NHS system. This finding is opposite of the theoretical expectations, which forecasted that the NHS system would have more uniform preventative policies due to its centralised character with the state as the principal actor.

6.2 Management

For cardiovascular disease management policies, both the Netherlands and England acknowledge the gender differences within cardiovascular disease management, highlighting the need for more research on more personalised care for women. However, for both countries, the policies remain rather aspirational, lacking a detailed implementation plan or concrete timeline. Further, similarly to preventative policies, when gender inequality is not mentioned in the policy papers, either 'health inequality' or 'socio-economic inequality' is referred to. Thus, for both the Netherlands and England the policy initiatives are generally designed and structured to address gender disparity.

Comparing both the cases of the Netherlands and England, the observed differences between the two cases are insufficiently substantial to justify conclusive statements on whether the NHS or SHI system provide more thorough and exhaustive cardiovascular disease management policies regarding.

7. Conclusion

In order to answer the explorative question 'How are policy initiatives aimed at reducing gender disparities in cardiovascular disease treatment designed and implemented across different healthcare systems', the cases of the Netherlands and England were compared.

This qualitative research looked at the healthcare systems of the Netherlands, which has a social health insurance system (SHI), and England, which has a national health system (NHS). The expectation was that the NHS healthcare system would provide more comprehensive and uniform preventive and management policies on cardiovascular disease treatment regarding gender disparities. However, based on the case studies of the Netherlands and England, this expectation was not entirely found to be true. Instead, for cardiovascular

disease preventative policies, the SHI healthcare system (the Netherlands) was found to have more thorough and exhaustive policies regarding gender disparity. Additionally, for cardiovascular disease management policies, the results were not substantial enough to draw definitive conclusions. Thus, these marginal differences could be explained by the healthcare systems of the Netherlands and England having more similarities than differences, for example, both demonstrating robust healthcare infrastructures, similar health policies in general, and comparable levels of healthcare spending. Further, gender disparity is a relatively new research topic, as could be derived from the conducted literature review and mentioning the need for more research found in most preventative and management cardiovascular disease policies.

In addition, one of the limitations of this research, regardless of the long timeframe, may be the rather limited amount of policy documents such as policy paper recommendations, governmental reports, and program evaluations available, making it more difficult to detect subtle differences between the two countries. Further, due to the close relations between the Netherlands and England, both before and after Brexit, may foster collaboration within health, potentially creating more comparable clinical guidelines and policies. For future research, conducting a large-N study by including more cases with various healthcare systems could expand the research and provide a more comprehensive understanding of how different healthcare systems address gender disparities in cardiovascular disease treatment. Furthermore, research on innovative policy approaches and programs addressing gender disparity in cardiovascular disease treatment may foster future policy development.

Despite the limitations, this thesis still has academic relevance and implications. Even though the findings were not profoundly significant, this research does add to this under-researched field of gender disparity (in cardiovascular disease) within health and therefore addresses the critical gaps in understanding how policy initiatives may influence treatment outcomes across various healthcare systems. Thus, it sheds light on dimensions of gender disparity in health that have yet to receive limited scholarly attention. Simultaneously, as societal relevance, this research has shed another light on the matter of gender disparity within (cardiovascular) health, which in actuality still has (health) implications for women. Therefore, this research may stimulate further dialogue about the importance of this matter within academia, healthcare settings, and the broader societal discourse.

Bibliography

Afzal, S., & Arshad, A. (2023). System within system: World Health Organization building blocks and public-private partnership in healthcare sector of Pakistan. *Annals of King Edward Medical University*, *28*(1), 1–2. https://doi.org/10.21649/akemu.v28i1.4989

Batra, G., Aktaa, S., Wallentin, L., Maggioni, A. P., Wilkinson, C., Casadei, B., & Gale, C. P. (2021). Methodology for the development of international clinical data standards for common cardiovascular conditions: European unified registries for heart care evaluation and randomised trials (euroheart). *European Heart Journal. Quality of Care & Clinical Outcomes*, *9*(2), 161–168. https://doi.org/10.1093/ehjqcco/qcab052

Blakeman, J. R. (2020). Words matter: Sex and gender as unique variables in research. *Advances in Nursing Science*, *43*(3), 214–227. https://doi.org/10.1097/ANS.0000000000000295

Böhm, K., Schmid, A., Götze, R., Landwehr, C., & Rothgang, H. (2013). Five types of OECD healthcare systems: Empirical results of a deductive classification. *Health Policy*, *113*(3), 258–269. https://doi.org/10.1016/j.healthpol.2013.09.003

Brindis, C. D., & Freund, K. M. (2018). The ramifications of recent health policy actions for cardiovascular care of women: Progress, threats, and opportunities. *Clinical Cardiology*, *41*(2), 173–178. https://doi.org/10.1002/clc.22896

Brinkerhoff, D. W., & Bossert, T. J. (2014). Health governance: Principal-agent linkages and health system strengthening. *Health Policy and Planning*, *29*(6), 685–693. https://doi.org/10.1093/heapol/czs132

Burau, V., & Blank, R. H. (2006). Comparing health policy: An assessment of typologies of health systems. *Journal of Comparative Policy Analysis*, *8*(1), 63–76. https://doi.org/10.1080/13876980500513558

Cleland, J. G. F., Swedberg, K., Cohen-Solal, A., Cosín-Aguilar, J., Dietz, R., Folláth, F., … Eastaugh, J. (2000). The euro heart failure survey of the euroheart survey programme:

A survey on the quality of care among patients with heart failure in Europe. *European Journal of Heart Failure*, *2*(2), 123–132. https://doi.org/10.1016/s1388-9842(00)00081-7

Department of Health. (2013, March 5). *Cardiovascular disease outcomes strategy: Improving outcomes for people with or at risk of cardiovascular disease*. Retrieved from https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy

Department of Health and Social Care. (2000, March 14). *National service framework: Coronary heart disease*. Retrieved from https://www.gov.uk/government/publications/quality-standards-for-coronary-heart-disease-care

Department of Health and Social Care. (2022, August 30). *Women's health strategy for England*. Retrieved from https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

Dion, D. (1998). Evidence and inference in the comparative case study. *Comparative Politics*, *30*(2), 127–145. https://doi.org/10.2307/422284

Fawcett, J. (2022). Thoughts about health policies. *Nursing Science Quarterly*, *35*(3), 378–382. https://doi.org/10.1177/08943184221092444

Fishkin, T., Wang, A., Frishman, W. H., & Aronow, W. S. (2022). Healthcare disparities in cardiovascular medicine. *Cardiology in Review*. https://doi.org/10.1097/CRD.0000000000000507

Gezondheidsraad. (2015, November 4). *Richtlijnen goede voeding 2015*. Retrieved from https://www.gezondheidsraad.nl/documenten/adviezen/2015/11/04/richtlijnen-goede-voeding-2015

Gezondheidsraad. (2023, February 7). *Richtlijnen goede voeding voor mensen met hart- en vaatziekten door atherosclerose*. Retrieved from https://www.gezondheidsraad.nl/onderwerpen/voeding/alle-adviezen-over-voeding/richtlijnen-goede-voeding-voor-mensen-met-hart--en-vaatziekten-door-atherosclerose

Guimón, J. (2019). Policy initiatives to enhance the impact of public research: Promoting excellence, transfer and co-creation. *OECD Science, Technology and Industry Policy Papers*, (81), 1–26. https://doi.org/10.1787/23074957

Hamberg, K. (2008). Gender bias in medicine. *Women's Health*, *4*(3), 237–243. https://doi.org/10.2217/17455057.4.3.237

Hall, P. M., & McGinty, P. J. W. (1997). Policy as the transformation of intentions: Producing program from statute. *Sociological Quarterly*, *38*(3), 439–467. https://doi.org/10.1111/j.1533-8525.1997.tb00487.x

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., . . . Gupta, G. R. (2019). Disrupting gender norms in health systems: Making the case for change. Lancet, 393(10190), 2535–2549. https://doi.org/10.1016/s0140-6736(19)30648-8

Iyanda, A., Boakye, K., & Lu, Y. (2021). COVID-19: Evidenced health disparity. *Encyclopedia*, *1*(3), 744–763. https://doi.org/10.3390/encyclopedia1030057

Kouvari, M., Souliotis, K., Yannakoulia, M., & Panagiotaskos, D. B. (2020). Cardiovascular diseases in women: Policies and practices around the globe to achieve gender equity in cardiac health. *Risk Management and Healthcare Policy*, *13*, 2079–2094. https://doi.org/10.2147/RMHP.S264672

Kuhlmann, E., Lotta, G., Fernandez, M., Herten-Crabb, A., Fehr, L. M., Maple, J. L. … Paina, L., (2023). SDG5 "gender equality" and the COVID-19 pandemic: A rapid assessment of health system responses in selected upper-middle and high-income countries. *Frontiers in Public Health*, *11*. https://doi.org/10.3389/fpubh.2023.1078008

Lameire, N. (1999). Healthcare systems – an international review: An overview. *Nephrology, Dialysis, Transplantation/Nephrology Dialysis Transplantation*, *14*(6), 3–9. https://doi.org/10.1093/ndt/14.suppl_6.3

Law, S. (2022). Impact of national health service on the United Kingdom health system. *Journal of Modern Nursing Practice and Research*, *2*(3), 1–3. https://doi.org/10.53964/jmnpr.2022007

Lindquist, E. (2006). Organizing for policy implementation: The emergence and role of implementation units in policy design and oversight. *Journal of Comparative Policy Analysis*, *8*(4), 311–324. https://doi.org/10.1080/13876980600970864

Lombardo, E., Meier, P., & Verloo, M. (2017). Policymaking from a gender+ equality perspective. *Journal of Women, Politics & Policy*, *38*(1), 1–19. https://doi.org/10.1080/1554477X.2016.1198206

McGuire, T. G., AlegríA, M., Cook, B. L., Wells, K. B., & Zaslavsky, A. M. (2006). Implementing the institute of medicine definition of disparities: An application to mental health care. *Health Services Research*, *41*(5), 1979–2005. https://doi.org/10.1111/j.1475-6773.2006.00583.x

Mehta, P. K., Gaignard, S., Schwartz, A., & Manson, J. E. (2022). Traditional and emerging sex-specific risk factors for cardiovascular disease in women. *Rev. Cardiovasc. Med.* 2022, *23*(8), 1-18. https://doi.org/10.31083/j.rcm2308288

Merone, L., Tsey, K., Russell, D., Daltry, A., & Nagle, C. (2022a). Evidence-based medicine: Feminist criticisms and implications for women's health. *Women's Health Reports*, *3*(1), 844–849. https://doi.org/10.1089/WHR.2022.0032

Merone, L., Tsey, K., Russell, D., & Nagle, C. (2022b). Sex inequalities in medical research: A systematic scoping review of the literature. *Women's Health Reports*, *3*(1), 49–59. https://doi.org/10.1089/whr.2021.0083

Ministerie van Volksgezondheid, Welzijn en Sport. (2022, September 16). *Integraal zorgakkoord: Samen werken aan gezonde zorg*. Retrieved from https://www.rijksoverheid.nl/documenten/rapporten/2022/09/16/integraal-zorgakkoord-samen-werken-aan-gezonde-zorg

Morgan, R., George, A., Ssali, S., Hawkins, K., Molyneux, S., & Theobald, S. (2016). How to do (or not to do)… gender analysis in health systems research. *Health Policy and Planning*, *31*(8), 1069–1078. https://doi.org/10.1093/heapol/czw037

Morgan, R., Mangwi Ayiasi, R., Barman, D., Buzuzi, S., Ssemugabo, C., Ezumah, N. … Waldman, L. (2018). Gendered health systems: Evidence from low- and middle-income countries. *Health Research Policy and Systems*, *16*(1). https://doi.org/10.1186/s12961-018-0338-5

NHS. (2019, January). *The NHS long term plan*. Retrieved from https://www.longtermplan.nhs.uk/

NHS. (2019, October). NHS health check best practice guidance. Retrieved from https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/

Or, Z., Cases, C., Lisac, M., Vrangbæk, K., Winblad, U., & Bevan, G. (2010). Are health problems systemic? Politics of access and choice under beveridge and bismarck systems. *Health Economics, Policy and Law*, *5*(3), 269–293. https://doi.org/10.1017/s1744133110000034

Ovseiko, P., Greenhalgh, T., Adam, P., Grant, J., Hinrichs-Krapels, S., Graham, K. E. … Buchan, A. M. (2016). A global call for action to include gender in research impact assessment. *Health Research Policy and Systems*, *14*(1), 1–12. https://doi.org/10.1186/s12961-016-0126-z

Parrott, T. M. (2002). Bringing gender into our discussion of policy issues. *Gerontology & Geriatrics Education*, *22*(4), 57–68. https://doi.org/10.1300/J021v22n04_05

Payne, S. (2009). How can gender equity be addressed through health systems? *World Health*

Organisation, *12,* 1–37.

Peckham, S. (2014). Accountability in the UK healthcare system: An overview. *Healthcare Policy*, *10*, 154–162. https://doi.org/10.12927/hcpol.2014.23914

Percival, V., Richards, E., MacLean, T., & Theobald, S. (2014). Health systems and gender in post-conflict contexts: Building back better? *Conflict and Health*, *8*(1), 19–19. https://doi.org/10.1186/1752-1505-8-19

Peters, S. A. E., & Woodward, M. (2022). Sex and gender matter in cardiovascular disease and beyond. *British Cardiac Society*, *108*(13), 994–995. https://doi.org/10.1136/heartjnl-2021-320719

Public Health England. (2017, September). *Action plan for cardiovascular disease prevention, 2017 to 2018*. Retrieved from https://www.gov.uk/government/publications/cardiovascular-disease-prevention-action-plan

Public Health England. (2017, September 29). *Public health England cardiovascular disease prevention initiatives, 2018 to 2019*. Retrieved from https://www.gov.uk/government/publications/cardiovascular-disease-prevention-action-plan

Rijksoverheid. (2022, May 31). *Verkenning vervolg op programma kwaliteitsgelden*. Retrieved from https://www.rijksoverheid.nl/documenten/rapporten/2022/05/31/verkenning-vervolg-op-programma-kwaliteitsgelden

RIVM. (2002, February 4). *Hart-en vaatziekten bij allochtonen in Nederland*. Retrieved from https://www.rivm.nl/publicaties/hart-en-vaatziekten-bij-allochtonen-in-nederland-cijfermatige-verkenning-naar-leefstijl#:~:text=Sommige%20factoren%20lijken%20meer%20voor,bijvoorbeeld%20Marokkaanse%20vrouwen%20niet%20roken.

RIVM. (2018, November 23). *Nationaal preventieakkoord: Naar een gezonder Nederland*. Retrieved from

https://www.rijksoverheid.nl/documenten/convenanten/2018/11/23/nationaal-preventieakkoord

Princen, S. (2011). Agenda-setting strategies in EU policy processes. *Journal of European Public Policy*, *18*(7), 927–943. https://doi.org/10.1080/13501763.2011.599960

Reibling, N., Ariaans, M., & Wendt, C. (2019). Worlds of healthcare: A healthcare system typology of OECD countries. *Health Policy*, *123*(7), 611–620. https://doi.org/10.1016/j.healthpol.2019.05.001

Ruiz-Cantero, M. T., Vives-Cases, C., Artazcoz, L., Delgado, A., del Mar Gracia Calvente, M., Miqueo, C. … Valls, C. (2007). A framework to analyse gender bias in epidemiological research. *Journal of Epidemiology and Community Health*, *61*(2), 46-53. https://doi.org/10.1136/jech.2007.062034

Schäfer, W., Kroneman, M., Boerma, W., Van Den Berg, M., Westert, G., Devillé, W., & Van Ginneken, E. (2010). The Netherlands: health system review. *PubMed*, *12*(1), 1–228.

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research*, *34*(5), 1101–1118.

Stramba-Badiale, M. (2010). Women and research on cardiovascular diseases in Europe: A report from the European heart health strategy (euroheart) project. *European Heart Journal*, *31*(14), 1677–1681. https://doi.org/10.1093/eurheartj/ehq094

Theobald, S., Morgan, R., Hawkins, K., Ssali, S., George, A. S., & Molyneux, S. (2017). The importance of gender analysis in research for health systems strengthening. *Health Policy and Planning*, *32*(5), 1–3. https://doi.org/10.1093/heapol/czx163

Theodore H. Tulchinsky, & Elena A. Varavikova. (2001). National health systems. *The*

new public health (pp. 623–693). San Diego, United States: Elsevier Inc. https://doi.org/10.1016/B978-012703350-1/50015-2

Thiriet, M. (2019). Cardiovascular disease: An introduction. *Vasculopathies, 8*, 1–90. Springer International Publishing AG. https://doi.org/10.1007/978-3-319-89315-0_1

Tsao, C. W., Aday, A. W., Almarzooq, Z. I., Alonso, A., Beaton, A. Z., Bittencourt, M. S., . . . Martin, S. S. (2022). Heart disease and stroke statistics—2022 update: A report from the American heart association. *Circulation*, *145*(8), 153–639. https://doi.org/10.1161/cir.0000000000001052

Villalba, E., Salvi, D., Ottaviano, M., Peinado, I., Arredondo, M. T., & Akay, A. (2009). Wearable and mobile system to manage remotely heart failure. *IEEE Transactions on Information Technology in Biomedicine*, *13*(6), 990–996. https://doi.org/10.1109/titb.2009.2026572

Ward, S., Bagley, C., Lumby, J., Hamilton, T., Woods, P. A., & Roberts, A. J. (2015). What is 'policy' and what is 'policy response'? An illustrative study of the implementation of the leadership standards for social justice in Scotland. *Educational Management Administration & Leadership*, *44*(1), 43–56. https://doi.org/10.1177/1741143214558580

Wendt, C. (2009). Mapping European healthcare systems: A comparative analysis of financing, service provision and access to healthcare. *Journal of European Social Policy*, *19*(5), 432–445. https://doi.org/10.1177/0958928709344247

Wu, X., Fritzen, S., Howlett, M., & Ramesh, M. (2018). *The public policy primer : managing the policy process*. Routledge. https://doi.org/10.4324/9781315624754

Zorginstituut Nederland (2011, April 11). *Pakketscan coronaire hartziekten: Gevraagde, aangeboden en verzekerde zorg vergeleken*. Retrieved from https://www.zorginstituutnederland.nl/binaries/zinl/documenten/rapport/2011/04/11/pakketscan-coronaire-hartziekten/Pakketscan+coronaire+hartziekten.pdf

Zorginstituut Nederland. (2023, August 29). *Hart voor vaten: Signalement passende zorg voor mensen met hart-en vaatziekten*. Retrieved from https://www.zorginstituutnederland.nl/publicaties/magazine/2023/10/02/signalement-passende-zorg-bij-hart--en-vaatziekten