Department of Health & Social Care

Open consultation

Women's Health Strategy: Call for Evidence

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Executive summary

We are seeking your views to help inform the development of the government's Women's Health Strategy.

This call for evidence is seeking to collect views on women's health. It will run for a period of 12 weeks and is open to everyone aged 16 and over.

The easiest way to participate in the call for evidence as an individual is by completing the public survey.

We also welcome written submissions from individuals or organisations who have expertise in women's health, such as researchers and third-sector organisations.

This consultation closes at 11:45pm on 30 May 2021.

Ministerial foreword – Matt Hancock

For generations, women have lived with a health and care system that is mostly designed by men, for men.

This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact women in different ways. Pregnant women and women of childbearing age are also under-represented in clinical trials, which can create troubling gaps in data and understanding.

This problem affects half of our population. It can lead to poorer advice and diagnosis and, as a result, worse outcomes. Symptoms can often differ between men and women, and studies show some conditions, like coronary blockages, are more likely to be misdiagnosed among women than men.

This 'male by default' problem of the past must be put right. Despite living longer than men, women spend a greater proportion of their lives in ill health and disability, and there are growing geographic inequalities in women's life expectancy. This makes levelling up women's health an imperative for us all and will support progress towards the government's commitment to extend healthy life expectancy by 5 years by 2035.

There's a lot of great work already underway. This government is working on the next Tackling Violence Against Women and Girls Strategy, and has announced plans for a new Sexual and Reproductive Health Strategy, which we plan to publish later this year.

Although this focused work is important, it is also important we take an end-to-end look at women's health, from adolescence to older age. So, we're bringing forward England's first Women's Health Strategy, to make women's voices heard and put them at the centre of their own care.

We know that not all women have the same experiences, so we want to hear from as many women as possible from all ages and backgrounds about what you think works well and what we need to change.

I'd urge you to come forward and have your say, so we can make sure our nation's health system truly works for the whole nation.

The Rt Hon Matt Hancock MP

Ministerial foreword – Nadine Dorries

As Minister of State in the Department of Health and Social Care, one of my key priorities is women's health. Throughout my time as Minister, it has become clear that there are some key themes which cut across different areas of women's health, and on which we must take action.

We know that damaging taboos and stigmas remain around many areas of women's health, which can prevent women from starting conversations about their health or seeking support for a health issue. When women do speak about their health, all too often, they are not listened to. Independent reports and inquiries – not least the First do no harm report and the Paterson Inquiry report – have found that it is often women who the healthcare system fails to keep safe and fails to listen to. We absolutely must change this.

In order to tackle taboos and ensure that women's voices are heard, I firmly believe that the provision of high-quality information and education is imperative. To give an example, the average diagnosis time for a condition as common as endometriosis is 7 to 8 years; it greatly saddens me to read how so many women think – or worse, are told – that the debilitating pain and symptoms they are experiencing are 'normal' or 'imagined' and they must live with it.

The department and the government have taken a number of important steps in this area. For example, to support work on the government's commitment to make the NHS the best place in the world to give birth, in September 2020, I established a Maternity Inequalities Oversight Forum. This forum brings together experts from key stakeholders to consider and address the inequalities for women and babies from different ethnic backgrounds and socio-economic groups.

Despite the progress that is being made, I am clear we can do more. I believe there is an opportunity to take a much more holistic approach to women's health across the life course, focusing on prevention and better integration of services. The government's integration and innovation white paper and our public health reforms will set the direction for a greater focus on integrated, person-centred care and prevention. We must ensure that this work delivers for women.

Women's input into society and particularly into our health and social care system has always been vital, but I would argue never more so than now. 77% of the NHS workforce and 82% of the social care workforce are women, and throughout the pandemic women have been on the front line ensuring that people receive the health and care they need. Investing in all aspects of women's health, including within the workplace, is essential to women's ability to reach their full potential and contribute to the communities in which they live.

We have seen both negative consequences and positive outcomes from this pandemic. It is, for instance, providing momentum for innovative new ways to deliver services. One of my key priorities is to improve research and evidence into women's health, and to finally tackle the gender data gap that still exists. If we have good evidence, we can identify the health and care needs of women; if we have good evidence, we can begin to identify what will work best for women in order to support improvements in women's health.

That is why we are embarking on the first Women's Health Strategy for England, with the ambition of improving health and wellbeing of women across the country.

We are launching this call for evidence to listen to women's priorities. We are also extending this opportunity to organisations, researchers, academics and clinicians who can provide further expertise. Importantly, by directly calling on women, we are re-setting the way in which the government understands women's health, with a renewed focus on listening to women's voices.

I encourage you to contribute to this call for evidence – by responding, you can make your voice heard and play a vital part in shaping England's first Women's Health Strategy.

Nadine Dorries MP

The Women's Health Strategy

The Women's Health Strategy for England will set out an ambitious and positive new agenda on women's health, with women's voices at the centre. We are launching this call for evidence to inform the priorities, content and actions within the Women's Health Strategy. This exercise will ensure that the strategy is evidence-based and reflects what women identify as priorities.

There is strong evidence of the need for greater focus on women's health and to recognise and act on the inequalities.

In the UK, women have a longer life expectancy than men, with life expectancy at birth being 83.1 for women and 79.4 years for men in 2017 to 2019. However, women in the UK spend a greater proportion of their lives in ill health and disability. Women spend around over a quarter of their lives in ill health or disability, compared with around one fifth for men. Moreover, in recent years, healthy life expectancy has fallen for women but has remained stable for men.

There are also differences in life expectancy across socio-economic groups. Taking action on women's health will support our commitment to extend healthy life expectancy by 5 years by 2035.

Work to develop the Women's Health Strategy will consider women's health over the life course, from adolescence through to older age.

We want to better understand women's experiences of health, and the health and care system. The strategy will focus on the needs of all women, as we recognise that women are not all the same, and that women will have individual needs and concerns. The government is ambitious about tackling health inequalities and the wider determinants of health, and a better understanding of the specific needs and areas of inequality faced by women will support this important work.

We want to understand more about issues that only affect women (for example, gynaecological conditions or menstrual health), and also issues that affect both men and women but may be more prevalent in women, or affect men and women differently.

This call for evidence seeks views on 6 core themes that connect different areas of women's health across the life course.

1. Placing women's voices at the centre of their health and care

In recent years, it has become clear that more could be done in terms of listening to women's voices. We know that women can face damaging taboos when wanting to start conversations about their health, which can make it more difficult to speak to healthcare professionals, family members, friends and employers. Embarrassment or stigma should not be a barrier to women seeking the help and care they need.

We also know that, when women do seek help for health problems, they do not always feel listened to or their concerns taken seriously. We are determined to place women's voices at the centre of their health and care, both at the level of individual patient–clinician interactions, and at the system level.

We want to understand more about women's experiences of having conversations about their health and where changes can be made to ensure they are heard.

2. Improving the quality and accessibility of information and education on women's health

High-quality information and education is essential for supporting women to stay healthy throughout their life, and to be empowered in making decisions about their health – for example, on treatment options for a health condition. It is also essential that healthcare practitioners can access the necessary information to meet the needs of the women they provide care for.

However, there is some evidence that many women struggle to access reliable information about many aspects of women's health. We know that awareness of symptoms including what is considered 'normal' can be low, and that women may not always be aware of the treatment and support available for common health needs such as menstrual health or fertility. These challenges can be a barrier to women seeking care. There is also some evidence that the level of awareness of different conditions varies among medical professionals and wider society.

The recent introduction of compulsory relationships, sex and health education in schools is an important milestone in increasing knowledge of female health conditions. Pupils are now taught the facts about several areas of women's health, including menstruation, contraception, fertility, pregnancy and the menopause.

We want to understand more about where and how health information is accessed and its quality, and where improvements can be made.

3. Ensuring the health and care system understands and is responsive to women's health and care needs across the life course

A life course approach focuses on understanding women's changing health and care needs across their lives, and how specific life events or stages of life can influence future health. For example, we know that women who have high blood pressure or pre-eclampsia during pregnancy are at greater risk of heart attack and stroke in the future. A life course approach also focuses on understanding wider determinants of health, the opportunities for preventative action to support women to improve their health and prevent or reduce the risk of ill health later in life.

However, there is some evidence that women can find it difficult to access services that meet their specific health needs – or meet all their needs in one place. We know that there are significant inequalities between different groups of women in terms of access to services, experience of services and health outcomes.

The government's recent integration and innovation white paper sets out proposals for a Health and Care Bill, at the heart of which is delivering integrated person-centred care. Alongside this, the government's public health reforms will more deeply embed prevention and health improvement expertise, capacity and accountability across national and local government and within the NHS.

We want to understand more about women's experiences of services across their lives, and the key opportunities for targeted action.

4. Maximising women's health in the workplace

Women make up 51% of the population, and 72% of women aged 16 to 64 are in employment. In health and social care, the proportion of women in the workforce is even higher, with 77% of the NHS workforce and 82% of the social care workforce being female.

There is some evidence that female-specific health conditions such as heavy menstrual bleeding, endometriosis, pregnancy-related issues and the menopause can affect women's workforce participation, productivity and outcomes. There is very little evidence on other health conditions, although we do know that common conditions which lead to sickness absence and leaving the workforce are more prevalent in women, for example mental health conditions, and musculoskeletal conditions.

We also know that women are more likely to have a long-term sickness absence and leave work following that absence compared with men. Women also continue to take on disproportionate responsibility for childcare and caring for the elderly or disabled, which can further impact both women's health and women's workforce participation – for example, women may find it harder to access healthcare while balancing work and caring responsibilities. Women are also more likely to report developing their own health condition, or that an existing condition had worsened, because of their caring responsibilities.

We want to understand more about women's experiences in the workplace, and opportunities for better supporting both women and employers.

5. Ensuring research, evidence and data support improvements in women's health

We have a world-class research and development system in the UK. However, we know that women have been under-represented in research, particularly women of ethnic minorities, older women and women of child-bearing age, those with disabilities and LGBT+ women.[footnote 1] This has implications for the health and care they receive, their options and awareness of treatments, and the support they can access afterwards.

Our ambition is to ensure that women's voices and priorities are at the heart of research, from identification of need to publication and implementation in practice, and that we have the right data and evidence to improve women's health outcomes and experiences of healthcare services.

We want to understand more about how research is used, and identify how areas of health and medical research has overlooked women's experiences and perspectives.

6. Understanding and responding to the impacts of COVID-19 on women's health

While the situation with COVID-19 is ongoing and in many cases it is too soon to draw conclusions on long-term impacts, we know that COVID-19 has had significant impacts on all elements of people's lives, including work, leisure, and the way in which people access health and care services. For example, we know that the gender gap in childcare has increased over the pandemic, putting an additional burden on working mothers.

We want to understand more about the impacts of COVID-19 on women's health, and on women's health services, including both challenges and positive reforms or opportunities for action.

Please note, the government has recently held a 3-month consultation seeking views on whether to make permanent the current temporary measure allowing for home use of both pills for early medical abortion up to 10 weeks' gestation. The scope of this call for evidence therefore does not extend to home use of both pills for early medical abortion up to 10 weeks' gestation.

How to respond

The aim of this call for evidence is to inform the priorities, content and actions within the Women's Health Strategy.

The easiest way to participate in the call for evidence as an individual is by completing the public survey. This will help us better understand women's experiences of health, and the health and care system.

We also welcome written submissions from individuals and organisations who have an interest and expertise in women's health. Written submission can include the contribution of data, research and other reports of relevance, and must be limited to 10 pages.

Read further guidance on written submissions.

Submit written submissions in word or PDF format here

Due to COVID-19, we cannot accept postal submissions.

Please contact whscallforevidence@dhsc.gov.uk if you cannot send an evidence submission via the online portal.

Next steps

The evidence gathered through this exercise will inform the priorities, content and actions in the new Women's Health strategy for England. It will ensure that the strategy is evidence-based and reflects what women identify as priorities.

We will respond to the call for evidence after the summer.

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1. Raz, L. and Miller, V. M. (2012) 'Considerations of sex and gender differences in preclinical and clinical trials' in 'Handbook of Experimental Pharmacology', no. 214, pp. 127 to 147; Hoffman, K.M, et al (2016) 'Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites' in 'Proceedings of the National Academy of Science of the United States of America', 113(16), pp. 4296 to 4301. ↩