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GENDER HEALTH GAP

Closing the gender health gap: a £39bn boost to the economy, as well as lives

The UK has the 12th largest gender health gap in the world. Closing it will require investment, but would also reap rewards for women and the country, reports Sarah Graham

Sarah Graham *freelance health journalist*

Closing the gender health gap by 2040 could add almost £39bn to the UK economy and give each British woman around 9.5 more days of good health a year. That's according to data shared with *The BMJ* by the McKinsey Health Institute, whose recent report with the World Economic Forum describes investing in women's health as a $1tn global opportunity, with a $3 return on investment for every $1 spent.[1]

The report quantifies the personal and economic cost of years lost to disability, ill health, and early death, and highlights that women globally spend on average 25% more of their lives in poor health than men. The economic case is compelling—by investing in research, innovation, and data collection and improving access to healthcare services, economies around the world could see a $400bn boost to productivity, as well as improving the health and lives of 3.9 billion women.[1] In March US president Joe Biden signed an executive order expanding the government's research on women's health, with $200m pledged for the following year.

A 2020 analysis of health data across 158 countries, carried out by men's wellbeing platform Manual,[2] found the UK had the largest women's health gap (where a country's ranking for women's health is lower than their rank for men's health) in the world.

The UK government published its women's health strategy for England[3] in summer 2022. This 10 year plan, informed by consultation with women's health organisations and more than 100 000 individuals, includes commitments on research, training, and service provision (see box 1). Lesley Regan—former president of the Royal College of Obstetricians and Gynaecologists (RCOG)—was appointed to support the strategy in the role of women's health ambassador in June 2022, and reappointed in January 2024 for a further two years.

Box 1: UK government spending pledges for women's health in England

- April 2022 - July 2023 £53m, through the National Institute for Health and Care Research (NIHR), for research with a focus on conditions specific to women's health—including endometriosis, menopause, and cervical cancer
- April 2023 - March 2025 £25m over two years—or £595 000 for each integrated care board—to establish at least one women's health hub in each area
- August 2023 New policy research unit dedicated to reproductive health commissioned, with an initial investment of £3m over three years
- January 2024 £50m for an NIHR challenge for research tackling maternal health disparities
- March 2024 £35m to tackle maternity safety, including £9m for tools training to reduce brain injuries in childbirth
- Total = £166m

Earlier this month, the NHS also appointed Sue Mann, a consultant and lead for women's health in City and Hackney, NHS North East London, as its first national clinical director for women's health—to "help implement the women's health strategy."

The strategy was welcomed by women's health groups, but questions were asked about how the plans would be funded. Edward Morris, then-president of RCOG, expressed concern about "the lack of dedicated funding to make these ambitions a reality."

More recently, women's health campaigner and author Kate Muir told *Femtech World*, "Until the women's health strategy is properly funded, it will just be a PR sticking plaster covering up ongoing chaos, misery, and year long waiting lists."[4]

Ringfencing research funding and upskilling researchers

Research investment will be vital to improvements in women's healthcare. Women have historically been excluded from, or underrepresented in, medical research, while conditions that predominantly affect women have been neglected and underfunded,[5] leaving large gaps in medical knowledge and understanding about female bodies.

Data from the McKinsey Health Institute show the UK's top 10 women's health conditions contribute to half of the health impact on gross domestic product. These conditions include premenstrual syndrome, ovarian and uterine cancers, and other gynaecological diseases,[6] but also depressive and anxiety disorders, migraine, asthma, ischaemic heart disease, and osteoarthritis.

In 2022, just 2.4% of public and charitably funded research in the UK went to reproductive health and childbirth—a total of £68.4m.[7] Fewer than 6% of grants between 2009 and 2020 in the UK looked at

female specific outcomes or women's health.[1] (It is not possible to differentiate male specific funding, McKinsey says.) And—unlike Canada, the US, and the EU's Horizon Europe funding scheme—the UK currently has no standardised policy to ensure researchers account for sex and gender in their work.

Filling these research gaps is one of the six key priorities laid out in the women's health strategy, with just over £100m of research investment announced so far, and a new policy research unit dedicated to reproductive health (see box 1).

"This is a good start, but more money will be needed," says Kate Womersley, an NHS psychiatry doctor and research fellow at the George Institute for Global Health and Imperial College London. Researchers and policy makers also need to take a much wider view of what constitutes women's health, she adds.[8]

"The commitments on research are quite vague in the women's health strategy. Women's health is any condition that affects girls and women at any point in their life. You're only going to get good care if you invest in high quality research—research that focuses on gynaecological and obstetric problems, but also research that looks at women's health in all specialties and takes seriously the intersectional factors of race and age."

Enter Medical Science Sex and Gender Equity (Message), a research project at the George Institute of which Womersley is co-principal investigator.[9] Message aims to improve sex and gender equality across the UK's research sector by co-creating a policy framework for research funders. This is to be released in the spring, Womersley says, and 29 organisations across the UK medical research community—including funders such as NIHR and journal publishers including *The BMJ*—have already signed a statement indicating their support.

"Researchers who apply for funding will need to follow these policies to meet funders' standards," says Womersley. "This will require upskilling a whole generation or more of researchers who haven't done this until now. There are time and training implications, and cost implications around increasing sample sizes to give meaningful findings for people of different sexes and genders."

Sustainable funding for care?

Investment in research must sit alongside investment in care. Rolling out a nationwide network of women's health hubs (WHHs) is a central part of the women's health strategy, promising a one stop shop for reproductive health in every integrated care board (ICB), which should help to bridge some of the gaps between primary and secondary care. The government's own economic modelling shows a £5 return on investment for every £1 spent on WHHs, but concerns have again been expressed about the sustainability of funding.

In March 2023, the government announced a one-off £25m investment in the scheme, with each of England's 42 ICBs to receive £595 000 over the following two years.[10] ICBs were encouraged to use their full funding allocation to establish at least one hub in their area. But ministers noted they were only expected to do so if running the hub would still be affordable once this initial investment runs out.

For health economics policy adviser Bridget Gorham at the NHS Confederation, this raised some questions. "Given it's intended to serve half the population £25m is not a lot of money. I started to look into arguments for more robust and sustained funding for an area that has historically been neglected," she says.

The NHS Confederation is now running its own economic modelling project, led by Gorham, to make that case. With their findings to be published this summer, Gorham's hope is that it will support further funding for the goals the strategy sets out. "It's a 10 year strategy with only two years of funding," she says. "We're trying to demonstrate the return on investment of having a healthy and productive 51% of the population, but with the caveat that this won't be an immediate return on investment because the inequalities in the system will take time to untangle."

Another problem, Gorham adds, is that when NHS England wrote to all ICBs in November, advising on immediate action to "achieve financial balance," women's health was not a protected budget. As a result, she explains, "we heard from several integrated care systems that their WHH funding ended up being thrown into the black hole to break even for the financial year. Because the funding isn't recurrent, the obvious question is how integrated care systems can continue the service after those initial two years of funding."

Similar misgivings are shared by RCOG. "Historically, investment in women's health services has been insufficient, short term, and siloed. We therefore welcomed the ambitious vision set out in the women's health strategy for England. WHHs are a very positive first step," says Ranee Thakar, president of RCOG.

She adds, however, "To deliver on the promise of the strategy and truly transform care to meet the holistic needs of women across their lives, a long term and sustainable approach to funding is needed. We urge the government to commit to this."

Robbing Patricia to pay Paula?

Another concern is that WHHs could come at the expense of improving women's health provision across the whole of primary care. A joint statement published by the Royal College of GPs, RCOG, the Faculty for Sexual and Reproductive Health, and the British Menopause Society[11] highlights existing workforce pressures across the health service and states that, "In order to make sustainable improvements to women's health and harness the benefits of the WHH model, there must be a focus on equipping primary care with funding, staffing capacity, and skills and knowledge to consistently deliver high quality women's healthcare."

Challenges also remain in secondary care, such as gynaecology waiting lists[12] and a shortage of 2500 midwives across England.[13 14] In March, as part of the spring budget, the government announced an additional £35m in funding to tackle maternity safety, including investment in training, as well as funding for 160 new midwives over the next three years.

"Any money for maternity services is welcome, but this new funding is still woefully inadequate. The promise of 160 midwives over three years is a drop in the ocean of the staffing crisis, and is unlikely even to replace the midwives who leave the register or retire during that time," says midwife Leah Hazard, author of *Womb* and *Hard Pushed: A Midwife's Tale*. "How can staff have protected time to complete the training that's been announced when there aren't enough midwives to cover clinical care? Once again, the Tories are tossing crumbs to a system on its knees."

The Royal College of Midwives cautiously welcomed the announced investment and, at the time of writing, was seeking clarification from the government on the role the new midwives (which equates to roughly one for each NHS trust) will play in the recruitment and retention of the wider midwifery workforce.

Womersley notes that there are also large gaps across women's wider health—in areas such as cardiovascular disease, diabetes,

dementia, and autoimmune disease—that aren't currently prioritised by the women's health strategy.

"We're going in the right direction, but I have worries about the longer term investment plan," says Hannah Wrathall, founder of women's health communications firm Wrapp Consultancy. "It would be good to have some reassurance, particularly in an election year, that this is a sustained, ongoing effort that's going to be ingrained in our health system regardless of political party."

Perhaps the real question then is not how much investment is needed to close the gender health gap but if stakeholders can count on consistent funding—and continued political will—to see it through. With significant potential returns on even relatively small investments (see box 2), not all changes will require large funding pots, as Regan has noted. But what will be key is effective implementation, strong leadership, and sustainable, long term planning.

Box2: The economic case for action—a lesson from the US

In the US—where the 1993 NIH Revitalization Act established guidelines for sex and gender inclusion in clinical research—non-profit organisation Women's Health Access Matters (WHAM) worked with research institution RAND to model the health and economic impacts of doubling funding for women specific research in four areas: autoimmune disease, brain health, cancer, and cardiovascular disease.

"We were conservative in our modelling, so we assumed small health improvements of 0.1% or less," explains Lori Frank, president of WHAM, who previously worked on the research as a RAND scientist. "Then we looked at how much is invested in women focused research, and across all the therapeutic areas we'd chosen it was 15% or less. We thought it was politically feasible to think about what might happen if we doubled that funding."

Take rheumatoid arthritis: women make up 60% of patients in the US, yet when WHAM looked at NIH funding for the disease they found that just 7% of the budget went to women focused research. By doubling that funding, even assuming just a 0.1% health improvement, WHAM's economic model showed a staggering 174 000% return on investment.[15]

"When you apply funding correctly, even under a budget constraint, you improve outcomes and so reduce your costs in the long run. It becomes a virtuous circle," says Valentina Sartori, a partner at McKinsey and one of the lead authors on the gender health gap report.

More women in decision making positions will help, she adds, but so too will stretch goals and incentives—for public and private funders—to help "force the system" and drive funding to areas of unmet need. As Sartori and her colleagues state in the report, "When tackling women's health, the solution is not to divide more slices of one pie: it's to make more pies."

SG is author of *Rebel Bodies: A guide to the gender health gap revolution.*

I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

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