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What would a gender-equal health service look like? How might we move towards it?

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Paper for the Commission on a Gender-Equal Economy

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1. Context

The NHS has long been talismanic in political campaigning, including the Europe Referendum. Danny Boyle's tableau for the 2012 London Olympics foregrounded the NHS through some strikingly gendered tableaux of nurses and beds. Despite almost universal understanding of the acronym, the large and complex organisational structure of health care services and practices in the UK is not well or widely understood by the general public nor even the political classes. Imagery and policies continue not only to foreground the NHS alone, but to make health care appear synonymous with hospital-based health care, resulting in competitive electioneering in a post austerity climate around 'how many new hospitals can we pledge to build'.

The iconography of these communications continues to present patients in beds, female nurses in uniforms, and frequently male doctors in white coats with stethoscopes. The underlying equation reads: more hospitals, more beds, more doctors and more traditional hospital-based nurses = better health care. There is a real disjuncture here between the arguments in the NHS Long Term plan (2019) - discussed further below - which stresses the prioritising of out-of-hospital care, and also a disjuncture with the realities of most people's routine experiences of accessing and utilising health care, experiences which are commonly community-based and predominantly delivered by female staff who are not doctors.

Furthermore, whilst social care has now a raised profile in the eyes of both the public and policy makers, the fundamental rooting of provision in community-based health care across *all* areas of need is still obscured by demarcations of funding streams and organisational structures. A pattern of increasing structural fragmentation and privatisation in health and social care in England together with the loss of public and community health services and commitments, through repeated "reforms" has resulted in a crisis of worsening access and quality of care at all levels, and exacerbated gendered and ethically discriminatory inequalities.

The disconnect in policy is most apparent in the new points-based immigration statement which it has been recognised will have a major negative impact on recruitment and long term workforce planning in key sectors of primary health care work [1] The health workforce is predominantly female, hierarchically structured by gender and ethnicity, and deeply dependent on migrant staff (Section 3). Nursing, a profoundly gendered professional category, forms the core of the health workforce here, as worldwide. At each stage of NHS reorganisation since the 1980s, including contracting and managerial reforms, changes have tended to remake disadvantage, systematically undervaluing the lower paid, largely female staff who care for the most vulnerable members of the population, many also female (Section 4). Strikingly, the mountain of evidence from enquiries, reports, statistical returns and qualitative feedback demonstrating negative impacts of systematic direct and indirect cuts in health care funding across the country is poorly disaggregated by gender, making it hard to document the many ways in which women have suffered disproportionately as both users and providers of services (Sections 3 and 4).

Sexual and reproductive services are core elements of health care responding to women's needs. These services also have a long history of understanding and addressing the complexities of gender and gendered experiences (Section 5). They have also been persistently fragmented and peripheralised. A gender-equal health care agenda has no alternative but to address the now widely acknowledged impact of a binary concept of gender in excluding transgender and non-gender-binary people, and society's increasing shift to an understanding that concepts of gender include dimensions of self-identification and performativity. Data categorisation and collection is gradually recognising this, although not yet universally across the health sector, and this will continue to develop.

2. Recommendations

- To address gender equality, more resources are required for health care *and* these need to support a major relative shift in funding towards community and primary care including social care and public health.
- That funding shift must be accompanied by more transparent and effective long-term funding to integrate currently fragmented community and primary services; this in turn means reducing fragmentation of funding channels.
- To move towards a more gender equal health workforce, greater recognition and reward is required for increasingly complex clinical nursing skills, roles and leadership which will need to be further developed and valued.
- To strengthen and integrate more gender-equal community and primary services, much stronger roles and representation for nursing are required at all levels of the design, monitoring and delivery of services.
- Moves towards gender equality require raising the status, funding and recognition of sexual and reproductive health services as a core element within health and local authority planning.
- To plan for gender equality, better data are required on gendered experience, access, utilisation and impact of all health services, integrated into routine monitoring of ethnic, socio-economic and other forms of disadvantage.
- Data collection for gender equality planning should build on the in-depth understanding within sexual and reproductive health services of the complexities and the scope for moving away fro**m** definitions based solely on birth-assigned gender**.**

3. Gender, ethnicity and health care funding: some data and its limitations

Health, social care and social work are major employers within the UK economy: in 2018, 13.2% of UK employees, and 17.5% of all UK *part time* employees, were in human health and social work activities, the second largest industrial employment category after wholesale and retail trade[2], and employing around 4.4 million people in 2019[3].

This large sector, including all of health and social care is, furthermore, is a strikingly female enterprise: 78% (3.45 million) of these employees were female in 2019[4]. The pattern is consistent across the health sector, as is shown by the data for England[5]. In the NHS General Practice workforce in England, 85% of the workforce was female in September 2019[6]. In the NHS Hospital and Community Services workforce, 77% were female in 2019[7]. In the "independent provider health care" sector in England (where data are much less reliable), of 46,641 recorded *full time-equivalent* employees (the only data provided) in March 2019, 79% were female[8]. In UK residential care, where 93% of employment is in the private sector[9], women also predominate. In adult social care in England, an estimated workforce of 1.49 million is 83% female[10].

Across the whole sector, this female-dominated workforce is hierarchically structured by gender. In the NHS Health and Community Services workforce in England, doctors and senior managers top the hierarchy. Of women Health and Community Services (HCS) staff in England (not including primary care), 6% are doctors and dentists; of male HCS staff, 22% are doctors and dentists. However the pattern in medicine is changing: among medical staff, the gender split is moving towards equality, with 53% of doctors in training and 54% of GPs female. However, still only 37% of consultants and 27% of surgeons are women. [11]

Among the lower paid HCS staff, nurses and health visitors were 88% female in 2018, as were almost 100% of midwives and 82% of workers supporting clinical staff[12]. In General Practice in England in 2018, 95% of nurses (but just 90% of advanced nurse practitioners) were female.[13] The residential care sector is predominantly staffed by low-paid women, some with nursing qualifications.[14] Finally, social care is sustained by unpaid carers, estimated at 7 million in the UK in 2017[15], who are also predominantly women.

The health workforce is also ethnically diverse (indeed, more diverse than the working population as a whole), and hierarchical structuring by ethnicity most notably for nurses and non-medical staff, intersects with gender hierarchy. Recent HCS data for England[16] show 10% of all staff identifying their ethnicity as Asian, 6% as Black, and 79% as White. Again, these data do not include agency staff. Medical staff are diverse: 30% declared Asian ethnicity (31% of senior doctors), 5% Black (4% of senior doctors) and 56% White. Of senior doctors 57% (60% of consultants) declared White ethnicity, and 53% of junior (trainee) doctors. For all HCS nurses (except agency staff), 20.5% categorised themselves in 2019 as in a Black or a member of another ethnic minority (BME)[17]. Consistently, the higher the pay band, the lower the proportion of BME nurses, midwives and health visitors in the band. Across the 231 NHS trusts in England, in January 2019, there were only eight (3.5%) BME chief nurses.[18] Data on ethnicity in general practice and the "independent sector" seem to be poor. In 2016, around 25% of GPs declared a BME ethnicity, but there were large data gaps.[19] We have yet to find ethnicity data for nurses in general practice and for private sector staff.

These patterns are reflected worldwide, and the UK reliance on migrant staff damages low income populations' access to care across the world. Nurses and midwives contribute nearly 50% of the healthcare workforce in many countries[20]Out of a total of 43.5 million health workers it is estimated that nearly 50% (20.7 million) are nurses and midwives, most of whom are women. There is a shortage of nurses and midwives in most countries, and women shoulder the burden of informal care. Nurses provide up to 80% of Primary Health Care across the world, and primary care is 'first contact health care' which is usually provided in outpatient or community settings that emphasises the patient's general and holistic health needs.

The reform of nurse education in the UK during the 1980s removed student nurses from the workforce as frontline carers and replaced them with health care assistants on the lowest rung of the nursing hierarchy and pay scale. Migrant nurses struggling with complex and expensive registration procedures often found themselves forced to work as health care assistants often on less than the minimum wage in nursing and care homes rather than as qualified hospital nurses. The increasing commercialisation and marketization of the residential nursing and care home sector sits on the intersection of patterns of local and global division and disadvantage, sustaining and sustained by the vulnerability of migrant nurses. Incremental changes in care and policy in the UK have shifted much of the most disadvantaged segment of care work into a low paid and poorly regulated private sector. There are global implications of such migrant nursing labour. Similar patterns, damaging to low income populations' access to care across the world, are reflected across high income countries. International nursing and health care labour flows, which differentially involve women, have global implications for women's health.

In contrast to the relative availability of data on gender and the health workforce, data on women's use of the NHS and other health services appears relatively poor[21]. It has been very hard in the time available to find detailed statistics on equity in the use of health services by women, or an overview of gender as a key aspect of health equity in access to NHS services. Data sources (e.g. NHS Digital reports) focus on use of specific services of known importance to women: maternity and child health, mental health, and reproductive health.

However, overviews on e.g. health equity trends nationwide are strikingly poorly disaggregated by gender, and a similar problem arises in a number of recent key service assessments. For example, the Kings Fund report on Social Care for Older People[22] does not appear to mention "women" or "gender" at all. More surprisingly many of the health outcomes summary data, such as a welcome overview focusing on ethnicity, does not disaggregate by gender, even though women's and men's experiences are undoubtedly different[23]. Similarly, a recent health outcomes summary report for Scotland[24] mentions neither women nor gender. The latest PHE data on COVID-19 does not disaggregated data by gender, despite its importance for understanding and responding to infection control. Although we know, and the *Marmot Report* [25]emphasised that gender is an important driver of health inequality, this perception is not currently framing routine data presentation and review of health inequalities. Section 4 returns to the (re)making of gendered disadvantage.

Despite these data gaps, there are a number of known equality issues for women in terms of access to NHS and social care. They include[26]:

- problems of quality and access in maternity care;
- higher demand by women than men on very stretched mental health services (but lower rates of admission);
- very inadequate children's mental health services which may disproportionately affect women as carers;
- intensifying problems of access to primary health care that disproportionately affect women who use these services more than men as carers and for their own health needs[27];
- poor quality acute care and mental health provision for dementia sufferers, which disproportionately affects women (given their longer lives);
- less effective acute care in some aspects for women than men e.g. in cases of cardiac arrest;
- documented problems of clinicians' belief in women's reported symptoms e.g pain;
- issues of accessibility and quality of sexual and reproductive health care including confidentiality.

Women are disproportionately affected by problems of quality experienced in social, residential and nursing home care, since on average older men now spend 2.4 years while women spend three years with 'substantial' care needs[28]. Residential/nursing home care has also been notably discriminatory in the past for LGTBQ+ people e.g. in separation from partners.

Across the English health services, including public health and social care, the funding and governance structures since the 1990s have displayed a pattern of increasing structural fragmentation and privatisation. A series of reforms and reorganisations have driven new patterns of contracting for services, and accompanying marketisation and privatisation. The latest of these reforms, the Health and Social Care Act 2012 (the heavily contested "Lansley reforms"), removed the public health remit (responsibility for promoting the health of the population, as compared to responsibility for providing health services) from the NHS, giving it instead to local authorities who subsequently saw their budgets slashed. Centrally, the reforms intended that the NHS should cease to be a managed service. Instead it was to be subject to "a system of control based on quality and

economic regulation, commissioning and payments by results, rather than national and regional management", in the words of the white paper preceding it[29]. The explicit objective was thus to further fragment the NHS, away from a set of services managed in an integrated manner, and to bring in "independent" providers.

The culmination of this history of reforms has foregrounded its unsustainability. The marketisation reforms have consistently built in resource mechanisms that tend to pull resources towards acute hospital care. This leaches the primary and community levels; it tends to raise overall health system costs; it rachets-up pressure of demand on hospitals and primary, community and social care struggle; it has created spiralling deficits when implemented alongside a squeeze on NHS funding since 2010. As the next sections explore for specific examples, this rachet effect in the context of an overall resource squeeze predictably increases pressure most on the most disadvantaged, who most need support. Since, as noted above, socio-economic hierarchies are gendered, with women, and people of ethnic minority descent, particularly likely to be coping with service deterioration at primary care and community level while coping on very restricted budgets, this rachet effect inevitably worsens gendered disadvantage. The loss of public and community health services and commitments, and a crisis in primary care, emerge as core drivers of worsening access and quality of care, exacerbating gendered and ethically discriminatory inequalities.

Reversing the rachet implies reworking the hospital/primary/community hierarchy in funding in order to shift the balance of resources towards primary, community and social care. The difficulty in doing achieving this is exacerbated by the apparent lack of data on the current split in funding. The fragmentation of funding for hospital care among Clinical Commissioning Groups (CCGs), while at the same time acute hospital trusts have often had to take on support for community services left "homeless" by the 2012 Act's abolition of the Primary Care Trusts, has rendered the hospital/community funding split increasingly opaque. The latest (2017) *National Health Accounts*[30] estimate that approximately half of government-funded health care is spent on hospitals, roughly one quarter on "ambulatory providers" which means GPs, dentists, other community services. Around 10% was drugs and pharmacies; around 8% long term care.

There is now a government consensus, expressed in the *NHS Long Term Plan,* that two aspects of this situation are unworkable: the fragmentation of service planning and management, and the leaching of funding from primary and community care. The *NHS Long Term Plan* contains a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment – an NHS 'first' - creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24.

At the same time, there is a variety of initiatives to consolidate and integrate services and funding: they include mergers of CCGs into much larger funding bodies; new "network" funding to support local collaboration; "sustainability and transformation" plans; integrated care providers; and a plethora of initiatives to try to keep people out of hospital. For example, "Community Hubs" are being created, aiming to focus on areas with greatest need and act as 'one stop shops' for women and their families: they are supposed to work closely with local authorities, bringing together antenatal care, birth facilities, postnatal care, mental health services, specialist services and health visiting services. There is also in the *Long Term Plan* a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24, to try to achieve faster access to community and crisis mental health services for both adults and particularly children and young people

The complexity and fragmented nature of these efforts is in part caused by the need to "work around" the impediments deliberately put into the 2012 Act to prevent re-integration of service management, and the split between local authority and NHS funding streams for public health initiatives that the Act embedded in law. It is also made more complex by the particularly sharp fragmentation of the community services, where only half are now NHS-provided, and the others are split among a pattern of local authority, charity and private providers[31]. The consensus on the need to shift spending sharply in relative terms towards the community sector is thus very welcome and to be supported: however, the government's own health governance and funding framework makes it extraordinarily difficult to achieve.

A longer historical perspective also reinforces this perception of difficulty. The focus of the current government's public statements on hospital building and medical staff recruitment, noted in Section 1, has echoes of an older model of mental health services based on building more and more architecturally impressive asylums. It took a radical, and initially unpopular, view 70 years ago to argue for community based mental health services with new non hospital based professional psychiatric staff and the transformation of nursing roles, and even today still remains chronically severely underfunded, while fragmentation of referral and support services creates serious care quality concerns. Integration of community and primary care, including mental health, requires both different funding processes and a sharp shift in mindset.

4. Nursing and the remaking of disadvantage

Nurses work in a wide range of roles across the health and social care sector: in the NHS, GP practices, social care, private providers, higher and further education and the voluntary sector. Working in a wide range of employments contracts from direct NHS, PHE, NHS banks, nursing agencies, through to direct employment with private companies and other organisations, nurses are however united as a profession through common standards, a code of ethics, professional rights and responsibilities. It is this professional status and identity that has been most robustly defended against a sustained negative experience of pay and status recognition that has failed to value and recognise the level of skills, responsibility and autonomy that nurses hold.

In the early 1990s when the first major health care reforms hit the NHS, community nursing was a primary target. Professional nursing was fragmented and split from personal care delivered by newly formed private care companies that expect their front-line carers to work in 30-minute slots to deliver the most complex care. Our body of research over two decades[32] shows that hierarchies within health and social care reflect society's hierarchy of disadvantage. As a result, the gendered interaction of disadvantaged staff with disadvantaged patients has constantly reworked the nature of disadvantage at each stage of reforms. It is often the most marginalised staff (centrally including women migrants) who are caring for the most vulnerable patients (the elderly and the chronically ill), and this type of pattern has continually reasserted itself as the management and commissioning hierarchies changed. Not only was there no effort to prevent this remaking of disadvantage, but the reforms actively saved costs by ratcheting up pressure on the most vulnerable and distancing management of front-line care from those who understand it best.

In primary health care, it is nurses who are the dominant providers, managers and researchers and who like other front line workers are the field signallers, conveying the critical intelligence of what is and what is not working. The professional knowledge base of nursing is intrinsically holistic and whilst it has developed into major specialisations it has always retained that core of working across boundaries and finding ways to pull resources together for people's needs. [33] The boundaries between what nurses do and what doctors do are being challenged, blurring and shifting worldwide. Historically nursing practice, acutely gender-framed and conceived within a hospital setting, has a powerful iconic representation that works as a blockage on effective and much needed change.

However, these historic and deeply embedded limitations on nursing are now increasingly and extensively challenged by the development of new nursing specialisms and nurse prescribers, by team working and multi-skill community provision, notably involving new overseas recruits.

Over a long period nursing hierarchies have been built institutionally on social class and ethnic disadvantage, and managerial reforms within nursing have tended systematically to disadvantage lower paid, largely female staff who care for some of the most vulnerable members of the population, a high proportion also female. In the context of extensive reliance on professional staff trained outside the UK this has been reinforced by commercialisation of care provision, and the reliance of care homes on migrant, qualified but not (yet) registered, hence underpaid nursing staff[34].

After the 2012 reforms, representation of a Governing Nursing Board (GNB) voice on CCGs in 2013 was initially welcomed by the profession although at local levels this has often been perceived by community health care staff as not representative of local population health care needs but rather as prioritising governance and managerialism. [35]This tension within the profession between senior leadership coming out of acute-care career histories and frontline community-based staff is reflective of hierarchy-based tensions within wider health and medical communities. Whilst these are challenges within the profession, it is important that this wider picture does not obscure the importance of ensuring local community nursing voices are fully represented directly at all levels of commissioning and strategic planning.

Health care is itself a synoptic term to cover a very wide range of tasks, skills and occupations that together work to provide environments and their services for quality provision. One of the often overlooked sectors of hospital health care work, in which women predominate, is an area that was early contracted out, namely cleaning, such as the lavatory cleaners, the sharps bin collectors, the emergency and routine floor cleaners, the clearers of clinic detritus i.e. "the nasty stuff", and the general cleaning, mopping and damp dusting. These are all core activities for the safety and functional maintenance of institutional environments, however the NHS along with universities, the civil service, schools and other public services made these 'cleaning' workers early targets for outsourcing, often to global suppliers. In the NHS the impact of this was not only a major restructuring of jobs, pay and conditions but also a break from the integral roles this work and workers themselves had within the overall family of NHS. This already gendered work has become increasingly dependent on a gendered marginalized workforce with no opportunities or access to service management. The cosmetic trappings of corporate uniforms and badges however has not distracted women activists from raising a tide of protest with union support against the peripheralisation and treatment of this essential workforce. It is a similar picture in Social Care, although the lack of an institutional base from which to share experience, articulate and take forward concerns is more severely lacking in that sector.

In the context of nursing, and for the whole range of women's crucial lower paid work from social care to cleaning, a gender-equal health service could only be built by challenging the hierarchies (professional, managerial and definitions of skill) that undervalue nursing care in general and very particularly the types of nursing and health-related care that are particularly associated with - and needed by - disadvantaged patients and service users.

5.   Sexual health : A lens through which to explore a Gender Equal health service

Sexuality and Gender

Sexual health services are part of public health services whose funding and commissioning falls within the remit of local authorities' public health departments (PHE) rather than the NHS. Sexual Health is a paradigmatic case of fragmentation following commissioning and major reorganisation in

the NHS following the Health and Social Care Act 2012. All eyes have rightly been on social care, but sexual health has experienced similar chaos and collapse; it shares a similar historic pattern of complex funding, 'Cinderella' status and tangential interfaces with core NHS services and secondary health care. The age demographic of service users and demand is almost an inverted mirror image of social care, although the socio-economic profile of those for whom access and utilization is problematic is similarly disadvantaged.

Sexual Health services and staff have had to embrace far more radical understandings of the diversity of sexuality and gender identification than in the wider NHS. It is the nature of sexuality that it is constructed and reconstructed in socio-cultural contexts, and as these change so not only do behavioural patterns change but also the links between sexuality and gender identity become more fluid. Front line staff since the dark days of the 1980s' HIV crisis have some of the best knowledge and understandings of what is changing in sexual networks and landscapes. They have been in the forefront of recognising sexual violence against sex workers and other vulnerable groups. Like many other front line health care staff they are the 'canary in the coalmine' that warns of change and hazards ahead, and yet they have limited opportunities to inform policies and practice and are chronically undervalued at all levels of work and specialism. Morale is low, training opportunities limited and there has been an appeal by some to move back under the umbrella of the NHS where staff believe status and conditions of work are better, albeit without any guarantee that service quality will improve.

Gender was a pivotal axis on which sexual health policy was designed in the earliest days of the Contagious Diseases Acts of the 1860's when women were characterised as 'reservoirs of infection' and stigmatisation of sex workers has persisted. Sexual Health services today retain an imprint of the old disease control model whilst now framed within a New Public Health approach focussed on inter-agency work, community-based and local authority funded. In many ways this latter approach had the potential to take a 'population based' approach to health needs, but after the scrapping of Primary Care Trusts (PCTs) this opportunity was lost. The austerity budgets have hit local authorities very hard, and sexual health services, lacking strong local lobbying strength, were an early victim of cuts. There has been a 14% real terms reduction in local authority spending on sexual health between 2013-2018; the cut has fallen most heavily on Advice, Prevention and health promotion with a 35% reduction. Testing and Treatment have been prioritised within a 10% spending reduction. At the same time there has been a 13% increase demand for services resulting in a pattern of provision that is stripped back to mandated STI testing and contraception services, within a context of closures of Sexual Health centres that undermine access and utilization. This is a far cry from what twenty first century quality sexual health provision should be in the UK, it widens and compounds health inequalities and increases demand on the NHS and other social services.

Structural Fragmentation

Women's access to and experience of sexual health care suffers particularly from the structural fragmentation. For example, cervical screening is the responsibility of the NHS; so sexual health centres are unable to conduct smear tests along with other internal examinations or fittings. Hence women need to be referred for another invasive examination by a GP with long waiting times and frequently untrained in colposcopy: all this in a context of cervical screening take-up now at a twenty year low. It was this example of the failure to develop holistic working between commissioners to ensure smooth health care pathways that most shocked the Health and Social Care Committee members in 2019:

> *Rosie Cooper MP:* Really it is an à la carte menu: pick the bits you like and don't do the bits you don't like. Who the heck gives a damn really? How are you going to make sure that the service you are getting taxpayers' money for is being delivered? Why should it matter which area of the country you live in, and who likes which bit and who splits it all up and fragments it? Is there a regulator anywhere? Does anybody care? [36]

A similar case can be illustrated for long acting reversible contraception (LARC), which is known to be an effective type of contraception particularly for young and vulnerable women, and credited with being a major factor in the decline of teenage pregnancies. Products are funded by local authorities, but GPs are reluctant to provide them as part of their primary care remit as they perceive they are not properly incentivised for their time. The net result has been a 13% drop in their use. In written evidence to the House of Commons Select Committee on Sexual Health, the Faculty of Sexual and Reproductive Health argued:

> What happens then is that the most vulnerable in our society suffer, the woman with the pram cannot navigate her way through the system and get access to her needs. As a consequence, the use of long-acting, reversible contraception- there is good NICE guidance suggesting that it is the best form- is decreasing.

The overall picture for women's access to contraception is one of diminishing rights as Public Health England evidenced that one third of women are not able to access contraception from their preferred primary health care provider.

Prevention

In the broader policy context of preventive health care, the collapse of funding for sexual health advice, prevention and promotion is not only counter to all recent NHS long term strategic planning but it has major implications for women . Relationship and Sexual Health Education (RSE) is the platform on which sexual health services should sit; it is in this educational , non-clinical setting that young women can learn about issues of respect, boundaries and be confident in their assertiveness in relationships as well as thinking about and understanding their own sexual identity [37]. This spills over into multiple aspects of mental health and resilience. The government has failed to fund or take a strong stand to make this a compulsory element of the curriculum.

Prevention is the altar at which everyone wants to appear to genuflect, but it comes low down on their prioritising of health services funding. One of the paradoxes is that in a fragmented system the benefits of prevention do not accrue to prevention services themselves, only with integrated holistic health care can prevention be recognised as a key priority investment that benefits all aspects of health care in both the present and the future.

A significant contribution to redressing one of the many current inequalities in health care would be to radically rethink sexual health services , their purpose, mandate and coverage; to ensure that sexual health leadership and frontline workers have a voice in strategic needs assessments at all commissioning levels; to reverse the trend of declining funding and resultant closures and restricted access to local community based service centres; to properly fund them to include training and research; to develop systems for interagency collaboration and referrals ; and to develop specific services and delivery for hard to reach and vulnerable groups.   To do this would have many structural lessons for gender equality-focused policies in health.

6. Conclusion

There is a paradox at the heart of this paper: the NHS is a highly inclusive institution, still, one of the most inclusive, equitable health services in the high-income world. Which is why it commands such public loyalty. At the same time, the service is hierarchical, serves the most disadvantaged less well than those with more money and status, and its hierarchies are profoundly gendered to the detriment of service quality. Furthermore, the fragmentation and financial squeeze are reducing access and quality and exacerbating gendered inequalities in ways which are hard to track in detail for lack of data. This paper is

highly incomplete, reflecting our own limitations of knowledge and time, but also reflecting an apparent lack of good detailed evidence and overviews of gendered inequality in health care. Our recommendations therefore include much greater transparency of data collection on gender in health and social care. It would be desirable to evaluate reforms explicitly on the extent to which they mitigate or exacerbate what we have called the persistent "remaking" of gendered disadvantage.

The core structural recommendations however focus on integration of services and the shifting "downwards" of resources to primary and community care. In this sense, a gender equal health service is an equal health service, full stop. The more the resources move towards those in greatest need, and the more integrated and accessible community services become the norm, the more there is a move towards both gender equality and equality. In that process, moves towards gender equality will need to respond to: the specific needs of women; the specific needs of more disadvantaged women, and the needs expressed by those whose sexuality and self-identification does not fit binary norms. A change in the gender hierarchy, and gendered characteristics of health care staff – centrally including a revaluing and strengthening of nursing roles, is an essential part of the route to this, alongside the restructuring of finance and governance of the services.

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