

Equality in Health

The physical and mental health of women in the UK is compromised every day by a healthcare system that discriminates against them twice over. Diagnosis and treatment is based on male-centred research that ignores females' different biology; and gender stereotypes and biased medical textbooks lead to women's ill health being disbelieved and taken less seriously than men's. For the first time WE are putting sex and gender at the centre of healthcare policy to support healthier outcomes all round.

Transforming medical research and treatment

Women are disbelieved and dismissed by the health system. Studies estimate up to 85 percent of animals used in early stage biomedical research are male, and when females are included sex differences are not analysed in the majority of trials. Human trials are no better - researchers recruit more men because female hormones can "interfere" with results and because they worry that women won't disclose pregnancies. The result is that, in many cases, we simply don't understand the effect of drugs on women.

Women are 60 percent more likely to react to prescription drugs than men, yet prescription instructions give no warning of sex-linked effects. Public health programmes and diagnostic criteria for heart disease and attacks emphasise symptoms as they are experienced by men, despite this being one of the leading causes of death of women in Britain. And women's pain is less likely to be believed whatever the source.

Women are around four times more likely than men to be diagnosed with Medically Unexplained Symptoms (MUS). This label is given to symptoms not explained by medical science and so assumed

to be physical manifestations of emotional issues, rather than a gap in understanding. Being a woman is one of the “risk factors” of MUS that GPs are trained to look for.

WE will establish a health research institute for women and girls to invest in careful research and medical testing on females, and spearhead research on reproductive health throughout women’s lives. The institute will investigate any conditions or symptoms disproportionately experienced by women.

WE will update regulations and standards for the approval of clinical and pre-clinical trials to require them to systematically account for sex differences. For all existing medication, WE will require labelling to make it clear if testing and analysis has taken account of sex differences.

WE will review and reform medical curricula so that medical students learn to identify and treat diseases and conditions as they present in women.

WE will introduce quotas for commissioners of research such as NICE, universities and government representatives until they have 50 percent women on their decision-making boards.

WE will review ‘MUS’ with the aim of removing it as a generic (non-)diagnosis and incorporate medical training on gender bias and how that intersects with other inequalities including race, age, social class and disability.

WE will protect and fund effective community and voluntary organisations to provide specialist services, such as cervical screening clinics for survivors of sexual violence, and services designed to reach women and their families in deprived areas.

WE will fund transportation for disabled women to access health care.

Every aspect of health service should have a budget for British Sign Language (BSL) interpreters as they have for other languages.

A paradigm shift in mental health services

WE reject the framing that reduces mental health to a purely biomedical issue. Inequality and discrimination play a big role in mental ill-health.

Women are more likely to experience violence, to live in poverty, to live alone (particularly in older age) and to be carers for other people, all of which contribute to poorer mental health. Trauma and adverse childhood experiences, such as sexual abuse, gender-based violence and war and displacement are also key determinants. Almost twice as many women as men are likely to be diagnosed with anxiety disorders and 75 percent of those diagnosed with Borderline Personality Disorder (also known as Emotionally Unstable Personality Disorder) are women.

WE will update the Mental Health Act 1983 (England and Wales), the Mental Health (Scotland) Act 2015 and the Mental Health Capacity Act (Northern Ireland) 2016 to move them towards compliance with international human rights legislation and ensure that people are not harmed or abused within services. WE will address the over-use of detention ('sectioning'), particularly for people of colour, and train all mental health staff in a human-rights based approach.

WE will prioritise trauma-informed therapies - for example asking “what happened to you?” instead of “what is wrong with you?” - and working through the causes of mental health issues rather than focusing solely on the symptoms. WE will collaborate with service users wherever possible in the design and delivery of services, and commission local services based on communities’ needs.

WE will work towards having a mental health lead in every GP practice. For those in mental health crisis, WE will ensure access to non-medical crisis housing as an alternative to mental health acute wards.

In line with our Equal Education policies, WE will address early gender stereotyping that says men are strong and women are emotional - which is damaging to everyone. We will ensure every school has a mental health nurse. WE will also ring-fence funding for Child and Adolescent Mental Health Services (CAMHS) specialist services.

Gynaecological, reproductive and sexual health

Gynaecological research has focused on female bodies as vessels for reproduction rather than for health or pleasure. Little is understood about vaginal conditions such as vulvodynia and vestibulitis, and awareness of gynaecological cancers is low. One third of women in England suffer from severe reproductive health problems and 40 percent of women over 40 years old experience some kind of pelvic organ collapse. There are medical textbooks that omit the clitoris entirely, or label it without describing it as an organ.

WE will reverse cuts to specialist sexual and reproductive health (SRH) services, extend the ring-fencing of the public health budget beyond 2019-20 and plan further services by need;

reintegrating sexual health, reproductive health and HIV services that have been carved up since the Health and Social Care Act 2012.

WE will immediately suspend vaginal mesh surgeries in Wales and Northern Ireland, as in England and Scotland, and follow up on the Westminster Government's investigation to hold the relevant bodies to account for the pain and indignity suffered by thousands of women in the UK. WE will invest in research into effective and pain-free solutions to pelvic organ prolapse. WE will also investigate the prevalence of the so-called "husband stitch."

In line with our policies on reproductive rights, WE support the use of exclusion zones to prevent women being intimidated or shamed for having terminations.

WE will roll out training to ensure women are given information about all methods of contraception available from the NHS. WE will make emergency contraception free at the point of need, including pharmacies. WE will also allow pharmacies to dispense other forms of contraception.

WE will educate health professionals to ensure that cervical screening is offered to all women, including women not engaging in heterosexual sex and disabled women, who often encounter misinformation about their risks of developing cervical cancer. WE will also make sure that trans men and intersex people have equal access to cervical screening; and that all patients are consulted about what kind of examination is appropriate including, for example, the size of speculum used.

WE will require every GP practice to have at least one woman GP, as far as is practicable, as 62 percent of women - including a majority of Black Asian and ethnic minority women - would prefer to see a woman GP about sexual and reproductive health.

WE support a fully-funded NHS-provided fertility treatment service that is equitable across the UK, and does not discriminate, particularly against disabled women and LGBT women.

WE will ensure that pre-menopausal women who have been diagnosed with cancer are informed about and offered egg freezing before beginning treatment that will potentially be damaging to their reproductive system.

WE will bring in legislation to protect women who need to take absences from work resulting from menstruation or menopause symptoms, in line with provision for pregnancy support.

WE will support campaigns to promote positive and realistic messages about menstruation to tackle taboos and period poverty. WE will scrap the tampon tax.

WE will review regulations for labelling and advertising of feminine hygiene products such as vaginal washes and wipes that claim to be approved by gynaecologists, but which can in fact interfere with vaginal health.

WE will invite women engineers and designers to review medical equipment, such as mammograms and speculums, and suggest improvements for women.

Human rights and consent in childbirth and maternity care

Having a baby is the most common reason for admission to hospital in England, but the total cost of maternity care represents only around three percent of health spending. The need for woman-centred care, reduced medical interventions, increased support for breastfeeding and continuity of midwifery care is well-evidenced, but the reality falls far short.

WE will ensure women see the same midwife as far as possible throughout pregnancy and birth, and after birth. WE will increase funding for postnatal care, including for visits to women's homes, and support for pelvic health pre- and post-birth. WE will provide free choice and extension of provision for type and place of birth.

Some women report birth interventions that happened without their consent, including episiotomies (a cut between the vagina and anus) and instrumental births (use of forceps or suction cup). WE will review medical curricula to strengthen the concept of consent in training for midwives and doctors specialising in pregnancy and birth.

The current NHS insurance model also means that if there is a complication in birth that results in a fatality or long-term medical needs, financial compensation to the parents or child from the NHS requires someone to be at fault. This results in unnecessary interventions in birth known as "defensive practice". Instead of incentivising early intervention to avoid blame, WE will develop a 'no fault compensation scheme' and legislation.

Suicide is the biggest killer of women between six weeks and one year after giving birth. WE will make sure all women and their partners have timely and comprehensive access to high quality perinatal mental health services when they need it.

WE will develop family-integrated care models in neonatal services (involving parents in their babies' care when in intensive care) so that mothers and babies are not separated when their babies are born premature or sick. As pregnant women are at an increased risk of domestic abuse, which also increases the risk of babies being born premature and underweight, the model must incorporate prioritisation of mothers' agency and wellbeing.

Black, Asian and ethnic minority women, working class and poor women are more likely to die in childbirth than white wealthier women. WE call for urgent investigation into the causes of these deaths, and for outreach programmes for women from these groups to make sure they can access early maternity services.

WE will end the relocation of asylum-seeking women by the UK Border Agency during and shortly after pregnancy. WE will end any charge for maternity services (and any other health service).

WE will create parity of care for women in the criminal justice system through the Birth Companions Birth Charter (a set of recommendations for the care of pregnant women and new mothers in prison).

WE will put the International Code Against Marketing of Breast Milk Substitutes into UK law. WE will require employers to provide breastfeeding breaks, and safe, private and clean areas for feeding,

expressing and storing milk, to support the 80 percent of women who give up breastfeeding before they want to.

Equality in health means an end to violence against women

Survivors of gender-based violence are more likely to have poor physical and mental health. The health system has a vital role in identifying, intervening in and supporting women experiencing gender-based violence.

Working with professional health bodies and specialist violence against women (VAWG) services, WE will incorporate training, information and support for healthcare workers to improve identification of different forms of VAWG.

WE will require GP practices to provide information about gender-based violence, and signpost local services to patients.

WE will mainstream VAWG in health services, and work with health care regulators and VAWG services in each nation to include inspection criteria on best practice monitoring and intervention in gender-based violence and abuse.

WE believe Yarl's Wood detention centre should be closed down, but that in the meantime adequate physical and mental health care must be immediately provided to the women detained.

WE will guarantee refugees and immigrants the right to an interpreter to support their access to all health care services.

Equality in aging and end of life care

Women live longer than men and make up a larger portion of the older age population. Thus they are more likely to spend more of their life in ill health than men.

The care commitments that women disproportionately take on over their lifetime affect their own health as they age; caring is a risk factor for developing dementia, the leading cause of death for British women. In heterosexual couples, men are less likely to take on domestic work when their wives are living with dementia, which makes it more difficult for those women to access support services.

WE will work with services for older people and people with dementia to make sure women get the access they need to those services, and to understand that men in their life may act as a barrier. WE will review health, care and equalities legislation to ensure that the rights of those living with dementia are upheld. WE will make sure staff in care homes with deaf clients have BSL training.

WE will ensure that people who opt to die at home are given properly funded support to do so, to avoid end-of-life care falling to women. WE will also ensure that care home staff are equipped to care for people at the end of their lives.

WE will support community-based approaches to end of life care, such as “compassionate cities”, which join up services including hospices, churches and charities. WE will review current provision of end-of-life care to ensure a peaceful death and appropriate funeral, including support with advance directives and lasting powers of attorney while people are able to decide.

Working with organisations like Changing Places, WE will install a national network of accessible public toilets, so disabled and older people are not forced to use catheters or risk dehydrating in order to use public spaces.

Building a workforce for the future

Women are the backbone of our National Health Service (NHS), making up around three quarters of the workforce in each of the nations of the UK. But only 15 to 16 percent of Chairs of Clinical Commissioning Groups in England, which make local health service funding decisions, are women; and only 15 out of the 100 highest paid consultants in Scotland are women.

In order to create an equitable workplace for women it is vital to tackle ongoing issues such as pay restraint, the gender pay gap, lack of flexible working, and the bullying and harassment reported by 24 percent of NHS England staff.

WE will end pay restraint, reinstate the bursary for student nurses and midwives, and negotiate with the British Medical Association (BMA) and junior doctors for a fair and equitable contract that does not discriminate against women, who are more likely to have caring responsibilities. WE will make sure the process of applying for bursaries is simple and straightforward.

WE will introduce quotas for women as senior managers and directors, consultants, surgeons and specialists, and introduce criteria in the relevant national inspectorates to report on the progress of trusts. WE will also introduce quotas for male nurses and caring assistants, to improve balance at all levels.

WE will work with professional bodies and the workforce to make the NHS a leader in flexible and part-time working, including training opportunities, and to attract staff back from agencies.

WE will adopt a migration policy that allows the NHS to recruit and retain European staff, including lower paid health and care workers, and does not limit the number of staff the NHS is able to recruit from outside the EU.