LSE Public Policy Review

Barriers to Women in Accessing Healthcare in the UK – A Review

RESEARCH

GENEVIEVE JEFFREY

LSE Press

ABSTRACT

This paper examines the persistent gender health gap in the United Kingdom, highlighting disparities in healthcare access and outcomes between men and women. While women report higher morbidity rates across a range of conditions compared to men, healthcare research have historically been structured around male-centric models, leading to diagnostic delays, inadequate treatment, and unmet healthcare needs. The study explores the socioeconomic, systemic, and behavioural roots of these disparities, and consequences, which include reduced productivity and labour market inefficiencies. Key factors contributing to the gender health gap – such as caregiving responsibilities, financial constraints, workplace policies, and structural biases in medical research – are analysed. The effectiveness of the UK Women's Health Strategy (2021) is critically evaluated, focusing on policy interventions such as the expansion of women's health hubs, mental health support, and workplace reforms. Despite these measures, challenges persist, particularly in addressing intersectional inequalities affecting women from disadvantaged and minority backgrounds. The paper concludes by emphasising the need for a more comprehensive policy approach that integrates healthcare access with broader economic and social reforms to achieve gender equity in health outcomes.

CORRESPONDING AUTHOR:
Genevieve Jeffrey
LSE Department of Health Policy,UK
G.Jeffrey@lse.ac.uk

KEYWORDS:
gender health gap; healthcare access; morbidity-mortality paradox; women's health policy; socioeconomic disparities; healthcare utilisation; labour market and health; systemic health inequalities; public health economics; policy evaluation

TO CITE THIS ARTICLE:
Jeffrey G. Barriers to Women in Accessing Healthcare in the UK – A Review. *LSE Public Policy Review*. 2025; 3(4): 5, pp. 1–12. DOI: https://doi.org/10.31389/lseppr.122

DOI: 10.31389/lseppr.122

1. INTRODUCTION

The United Kingdom (UK) currently ranks 104th globally in terms of the gender health gap. There are significant disparities in healthcare access and health outcomes between men and women (1). This issue has increasingly gained policy attention in the United Kingdom, culminating in the launch of the Women's Health Strategy in 2021. This strategy aims to address systemic inequalities by recognising not only the fundamental equity concerns, but also the broader economic consequences, including reduced productivity and labour market inefficiencies stemming from these disparities.

Existing research on the gender health gap has centred on mortality differences, where women tend to outlive men. This phenomenon has often been described as a paradox, as women consistently report higher levels of morbidity throughout their lives. However, the underlying structural and systemic determinants of this paradox remain largely unexplored. Key factors, such as the distinct roles of men and women in the labour market, caregiving responsibilities, and the financial and time burdens related to accessing healthcare, have been neglected in academic and policy discourse. Further, by focussing on the higher male mortality rate, it has come at a cost to considering the gender gap in morbidity and the higher burden of morbidity faced by women.

This paper aims to provide a comprehensive analysis of the gender health gap by examining the various factors that contribute to its persistence and by exploring their intersections with existing policy frameworks. Section 1 outlines the key dimensions of the gender health gap in the UK, assessing how disparities in healthcare access and outcomes are measured and defined. Section 2 investigates the primary causes of these disparities, identifying the socioeconomic, behavioural, and systemic drivers that contribute to unequal health outcomes. Section 3 evaluates the effectiveness of current policy initiatives aimed at addressing gendered health inequalities, highlighting existing blind spots and gaps. This section also emphasises the intersection between labour market conditions and healthcare access, providing insights as to how these factors influence the persistence of the gender health gap. Finally, the conclusion presents evidence-based policy recommendations that integrate the insights derived from this study, with the goal of reducing health disparities and fostering a more equitable healthcare system in the UK.

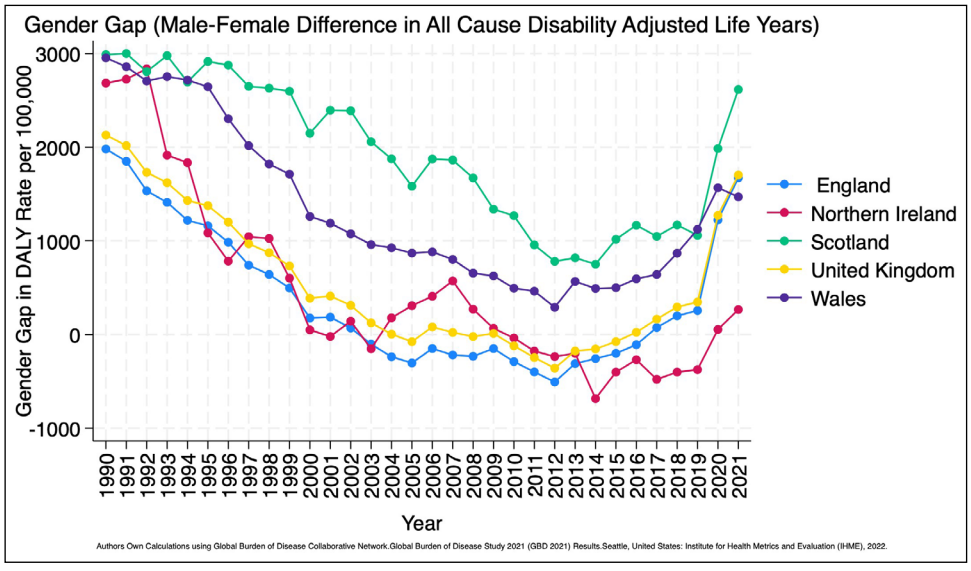

Figure 1 Data Source: IHME Global Burden of Disease (18).

2. GENDER HEALTH GAP IN THE UNITED KINGDOM

First, there are significant differences between men and women in terms of conditions related to mortality compared with conditions related to morbidity. Men have greater disability adjusted life years (DALYS) for outcomes related to mortality, like ischemic heart disease. Women have higher DALYS for morbidity driven conditions, like depressive disorders. The DALYS can be understood as the loss of one year in full health and is the combination of years of life

DOI: 10.31389/lseppr.122

lost to premature mortality (YLL) and years lived with disability (YLD) as a result of a health condition. The benefit of comparing DALYS is that we can then compare a health event that causes premature mortality to a health event that causes disability. By using DALYs, it becomes possible to compare diseases that cause early death but little long-term disability, such as drowning or measles, with those that may not be fatal but significantly impair quality of life, such as mobility loss from arthritis.

Second, there is the scale of the impact of outcomes related to mortality relative to outcomes related to morbidity. The DALY statistic combines Years Lost to premature death (YLL) and Years Lived with Disability (YLD). Together, the figure represents the years of healthy life lost. When we consider Figure 1 above, it is clear that for the majority of the time period under consideration, the DALY is higher for men than for women. This presents the false idea that men, on average, are in worse health than women and that men should be the policy focus, not women. Yet this DALY statistic obscures reality, presenting two separate issues (mortality and morbidity) as a singular one, to women's detriment.

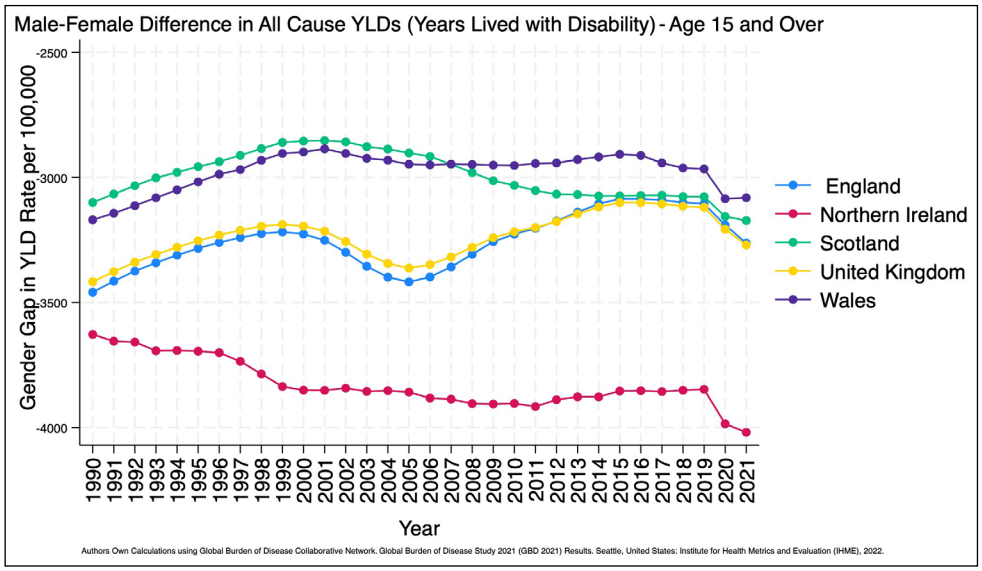

Figure 2 Data Source: IHME Global Burden of Disease (18).

KEY IDEA 1: WOMEN REPORT HIGHER MORBIDITY THAN MEN

Years lived with disability measures the years lived with any short term or long term health condition, and factors in not only the number of disabilities but also the severity of these disabilities. Figure 2 highlights how YLD has a greater effect on women than men in the UK. This aligns with research globally (2). Within the UK, the conditions that have the greatest gap between men and women are non-communicable diseases and gynaecological diseases. Other prominent conditions are musculoskeletal disorders, neurological disorders, mental disorders, headache disorders, low back pain and anxiety (according to 2021 figures).

An important point to consider is that the current ranking of the conditions that have the largest gaps between men and women is a product of the existing landscape in healthcare with the given medical evidence available and the existing barriers faced by women in access to healthcare. As the second section in this paper will highlight there are important gaps in knowledge that could cause gaps in diagnosis and the true picture could be marred by these gaps in evidence on disease prevalence in women as well as factors that hinder access to healthcare.

KEY IDEA 2: WOMEN HAVE GREATER HEALTH SEEKING BEHAVIOUR THAN MEN

While women face a higher morbidity, there is a large body of evidence that documents that they are more likely to seek medical assistance (see Figure 3) and are more risk averse in decisions concerning health (3) and in healthier diets (4).

Figure 3 depicts the significant gender disparities in booking general practitioner (GP) appointments, differentiated by the presence of long-standing illness. Among individuals without a long-standing illness, women are more likely to seek a medical appointment than

DOI: 10.31389/lseppr.122

men. Thirty-three per cent of women booked a GP appointment between 2020 to 2021, contrasted against only 19% of men. This trend persists even among individuals with chronic conditions, where 48% of women booked appointments compared to 37% of men.

The data suggests that women are generally more proactive in seeking healthcare services, reflecting well-documented patterns of greater health awareness and preventive care utilisation among females. Men's failure to do so to the same degree may potentially be due to social and cultural factors that discourage help-seeking behaviour, as well as perceived stigmas surrounding health concerns.

The fact that the gap narrows in the face of longstanding illness indicates that chronic health conditions may act as a stronger motivator for men to engage with healthcare services. However, the continuing persistence of the gap even here highlights the structural and behavioural factors at play in gendered healthcare utilisation patterns.

When we turn our attention from morbidity to mortality, prior research shows that behavioural differences account for up to 89% of the gender gap in mortality. One key factor is healthcare demand, which explains 70% of the gap, meaning that differences in how men and women seek and use healthcare significantly contribute to their respective life expectancies. Smoking behaviour, when factored in, raises this explanation to 89%, highlighting its major role in premature mortality differences between genders (5).

Wealth also plays a role – as individuals become wealthier and consume more, the additional benefits they gain from further consumption diminish. This means that while rising income improves health outcomes, its impact becomes smaller at higher income levels. However, the geographical dimension of the gender gap suggests that the extent of these influences may vary by country, making it important to consider regional differences in mortality trends and the underlying reasons behind these differences.

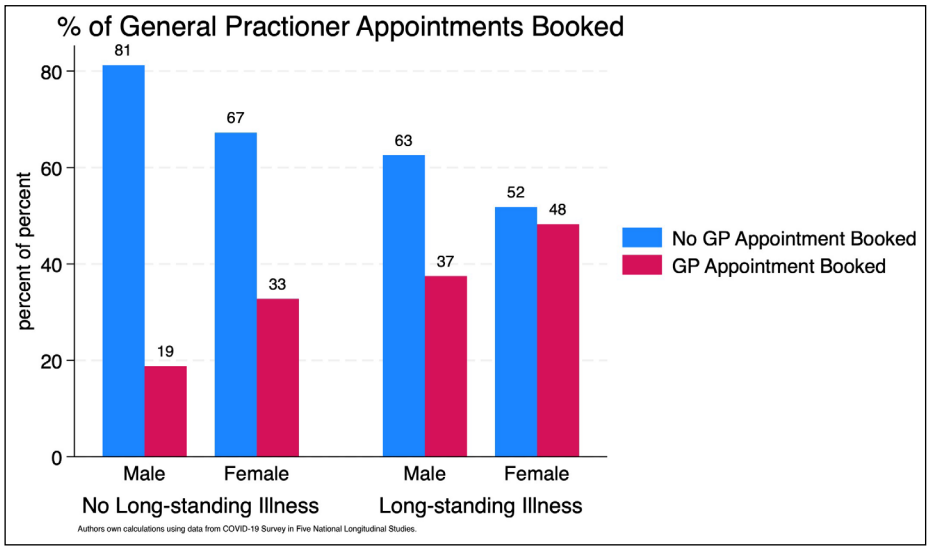

Figure 3 Data Source: COVID-19 Survey in Five National Longitudinal Cohort Studies: Millennium Cohort Study, Next Steps, 1970 British Cohort Study and 1958 National Child Development Study, 2020–2021 (19).

KEY IDEA 3: THE EXTENT OF GENDER GAPS IN HEALTH OUTCOMES VARY BY REGION IN THE UNITED KINGDOM

The observed trends in the gender gap in years lived with disability (YLDs) across the four UK nations reveal persistent disparities in health outcomes between men and women, with notable variations in magnitude and trends across regions. Over the past three decades, the gender health gap has remained consistently wider in Northern Ireland compared to other parts of the UK. In contrast, Scotland and Wales exhibit relatively narrower but still substantial gender gaps. England, with its larger and more diverse population, has shown fluctuating trends, suggesting a more complex interplay of regional healthcare policies and demographic factors.

In face of these geographical differences, a particularly striking development is the sharp increase in the gender gap observed after 2019 across all UK regions, indicating a deterioration

DOI: 10.31389/lseppr.122

in women's health outcomes relative to men. The widening of the gap after 2019, may also reflect the cumulative impact of COVID-19 that would have increased caregiving responsibilities and financial constraints, which may have exacerbated the disparity, leading to greater years lived with disability relative to men.

KEY IDEA 4: GAPS IN HEALTHCARE NEED AND ACCESS HAVE BEEN DOCUMENTED HISTORICALLY

The above findings on greater healthcare need by women have long roots and can be documented in the United Kingdom from the 1940s. Figure 4 presents data from the Survey of Sickness, conducted across England and Wales between 1946 and 1950, highlighting longstanding gender disparities in healthcare need and access across different income groups. Consistent with current patterns, women report a higher number of ailments than men across all income groups, reflecting a greater healthcare need. However, despite this higher burden of reported illnesses, the data reveals a notable discrepancy in healthcare utilisation patterns. While overall women have greater health seeking behaviour than men, we observe that when we disaggregate the data by socioeconomic status, women in the lower income groups have a lower incidence of medical consultations than men.

This divergence suggests potential barriers to healthcare access for women in disadvantaged socioeconomic groups, despite their greater need for medical attention.

A closer examination of the total days of incapacity metric further supports this interpretation. Women in lower-income groups report fewer days of incapacity relative to men, despite their higher reported morbidity. This pattern may indicate that women face greater constraints in taking time off work or caregiving responsibilities, which could prevent them from adequately addressing their health concerns through formal healthcare channels. The competing demands of unpaid labour and economic insecurity may compel women to prioritize immediate family or financial obligations over their own healthcare needs, leading to a cycle of untreated or undertreated conditions that could have long-term consequences for their health and well-being.

In contrast, among higher-income groups, the gender gap in healthcare consultations appears to narrow, suggesting that financial resources may play a mitigating role in addressing healthcare access disparities. The relative parity in consultations among wealthier individuals indicates that economic constraints are a critical factor driving the observed disparities in lower-income populations. Additionally, the distribution of incapacity days within higher-income groups suggests that women with greater financial security may have more flexibility to take medical leave, underscoring the role of socioeconomic status in shaping health-seeking behaviour.

A key point to note is that this data covers the period before the introduction of the National Health Service, and so access to healthcare was largely an out of pocket expense, and while health insurance was afforded to the lower socioeconomic groups, this largely excluded women and children which can explain the trends observed in reduced access consultations by women.

Examining pre-NHS data is valuable for understanding the historical roots of persistent gender disparities in healthcare access. While the NHS removed out-of-pocket costs and made healthcare universally available, gender gaps in utilisation remain. Studying the pre-NHS period helps isolate the role of financial barriers and assess whether disparities were primarily driven by cost or if other structural and behavioural factors—such as caregiving responsibilities, labour market participation, or differences in health-seeking behaviour—continued to shape outcomes.

If financial access alone explained these gaps, we would expect them to disappear post-NHS, yet they persist, albeit at a reduced scale. This suggests that while universal healthcare lowered cost-related barriers, other constraints—time, preferences, and social expectations—still influence healthcare decisions. Understanding these long-term patterns clarifies why gender gaps endure and highlights the need for policies beyond affordability to address persistent inequalities in healthcare utilisation.

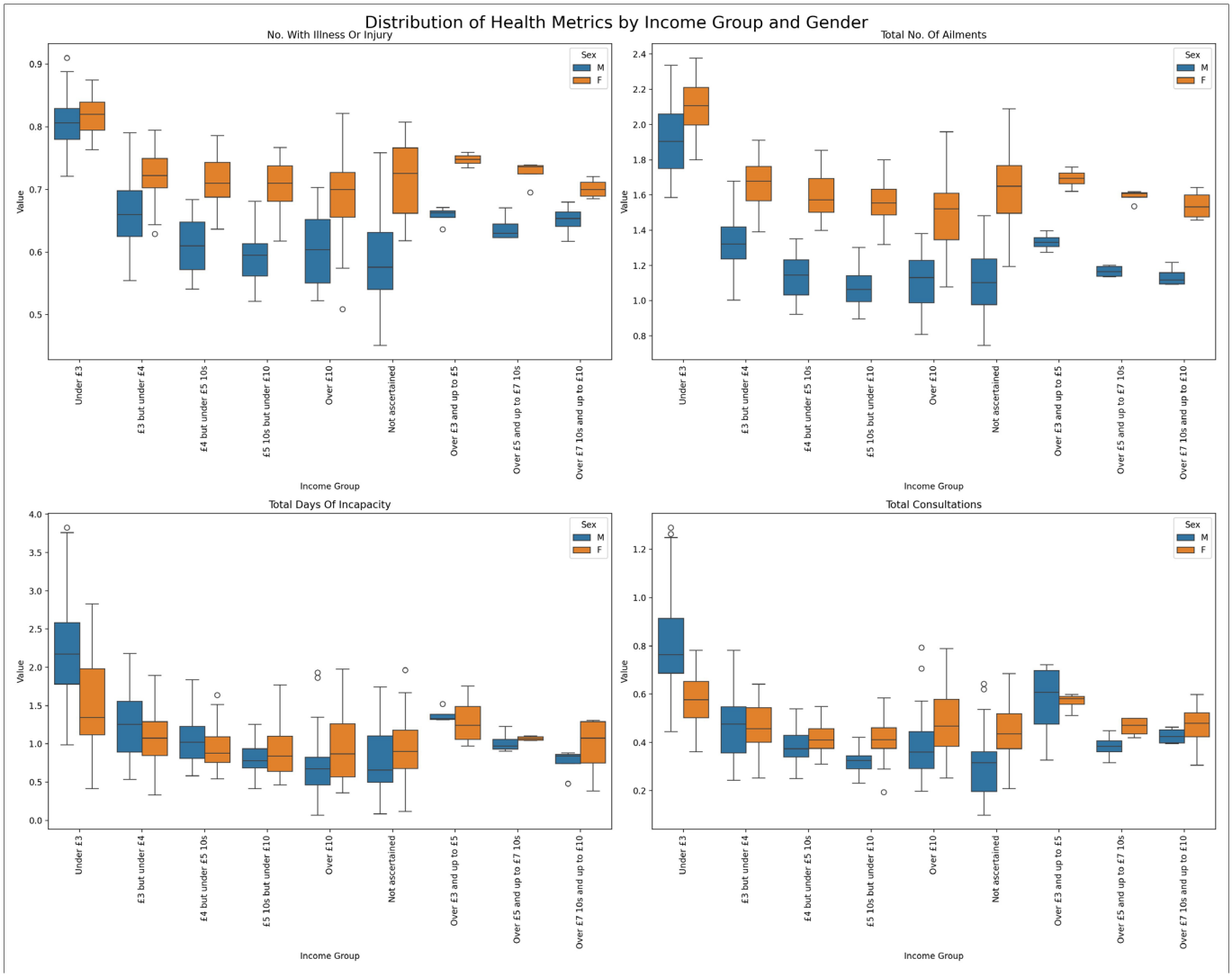

Figure 4 Data Source: Survey of Sickness.

3. CAUSES OF THE GENDER HEALTH GAP

The gender health gap in the United Kingdom arises from a combination of socioeconomic, behavioural, and systemic factors that collectively result in suboptimal health outcomes for women. Historically, medical research and clinical trials have predominantly focussed on male biology, leading to the pervasive underrepresentation of women in health studies and a consequent lack of understanding of female-specific health needs. This scientific bias has led to significant implications for the diagnosis and treatment of conditions that disproportionately affect women. For instance, endometriosis, a condition affecting approximately 10% of reproductive-aged women globally, remains vastly under-researched and underdiagnosed, with an average diagnostic delay of around seven years (6).[1] This delay exacerbates suffering, reduces quality of life, and imposes substantial healthcare costs. Similarly, conditions such as polycystic ovary syndrome (PCOS) and menopause-related complications receive inadequate attention in mainstream healthcare policies and research agendas. The persistent bias in research methodologies not only hampers the development of effective treatments but also restricts women's access to accurate health information, influencing their healthcare-seeking behaviour.

Behavioural Factors: Cultural and behavioural norms significantly shape women's health-seeking behaviours (7). Women are often socialized to prioritize the well-being of their families over their own health, leading to delayed or forgone medical consultations. This is particularly evident among women in low-income households, who face competing demands between employment and caregiving responsibilities. Data from England in 2015, 2017, and 2019 show that female unpaid carers were consistently more likely than male carers to report adverse health effects from their caregiving responsibilities. This gender

1 The data found a 27-year delay for the United Kingdom.

DOI: 10.31389/lseppr.122

disparity, with a gender gap of 10% for any health effect, highlights the greater physical and emotional burden faced by women in unpaid caregiving roles. There is a clear need for targeted support and interventions (8). Additionally, stigma and embarrassment surrounding female-specific health issues such as menstrual disorders (9), infertility, and menopause contribute to a reluctance to seek timely medical intervention. One issue with barriers to accessing healthcare is the tendency to self-manage symptoms using over the-counter remedies or alternative medicine rather than seeking professional medical advice which can exacerbate health disparities (10). Moreover, a lack of awareness or misinformation about available healthcare services and preventive measures further hinders women from accessing appropriate care, increasing their risk of developing chronic conditions that could have been managed effectively through early intervention. In March 2021, the Department for Health and Social Care (DHSC) launched a call for evidence to inform England's first-ever government-led Women's Health Strategy, revealing that while women primarily rely on family or friends (74%), Google search (71%), other online sources (69%), GPs or healthcare professionals (59%), and the NHS (54%) for health information, there is a significant gap in reliable and accessible resources on women's health, with fewer than 1 in 5 having sufficient information on menstrual well-being (17%), gynaecological cancers (14%), menopause (9%), FGM and sexual assault centres (9%), and gynaecological conditions (8%) (11).

Socioeconomic Factors: Socioeconomic inequalities remain a critical driver of health disparities, disproportionately affecting women from disadvantaged backgrounds. Financial constraints, caregiving responsibilities, and gender-blind workplace policies collectively create significant barriers to healthcare access. Women in low-income households often struggle to afford medical treatments and encounter workplace inflexibility, limiting their ability to take time off for healthcare needs. Evidence from the *Survey of Sickness* indicates that women in lower-income groups report a higher number of health ailments compared to men but are less likely to seek medical consultations. One possible explanation for this anomaly is that caregiving responsibilities and inadequate workplace support deter women from prioritizing their health. Many women delay seeking care for chronic conditions such as postpartum depression and chronic fatigue syndrome due to financial insecurity and the pressure to balance unpaid caregiving duties with employment obligations. Furthermore, higher reported days of incapacity among women underscore structural labour market constraints, such as the absence of paid sick leave and rigid working hours, which disproportionately hinder their ability to address health concerns effectively. One study found that severe menopause symptoms resulted in a five percentage point decrease in participating in the labour force in the UK (12) highlighting the implicit impact on the economy, which can be understood as the confluence both of a failure of the healthcare system on alleviating the symptoms of these conditions, and the inflexibility of employment in accommodating these women.

Systemic Factors: From an institutional perspective, the persistent underinvestment in women's health contributes to the entrenchment of health inequalities. Despite policy initiatives such as the *Women's Health Strategy* launched in 2021, aimed at addressing gender disparities in healthcare access, the financial commitment to women's health remains disproportionately low relative to the prevalence and economic impact of female-specific health conditions. In 2020, only 5% of global research and development (R and D) funding was allocated to women's health research, with 4% directed towards women's cancers and a mere 1% for all other women-specific health conditions. Even within this limited funding, 25% was further concentrated on fertility research, leaving numerous critical health issues underfunded (13). Another example is in digital health funding where FemTech companies received just 3% of the total (14). This lack of investment perpetuates a vicious cycle of limited scientific research and innovation tailored to women's needs. cardiovascular diseases, a leading cause of mortality among women, are frequently misdiagnosed or attributed to stress and anxiety, leading to delayed treatment and poorer outcomes compared to men (15). Intersectional disparities further complicate the gender health gap, with women from racial and ethnic minorities facing compounded challenges due to cultural, economic, and systemic barriers that hinder access to quality healthcare services. These challenges are further exacerbated by the absence of gender-specific strategies within the UK's healthcare system, which fails to account for the distinct health trajectories and healthcare needs of women across different life stages.

DOI: 10.31389/lseppr.122

The persistent challenges highlighted above suggest that the gender health gap may be even more severe than currently acknowledged, as underdiagnosis and treatment delays contribute to worse long-term health outcomes for women. While much of the policy focus has been on improving access to healthcare services, insufficient attention has been given to whether women can realistically utilise these services due to competing work and caregiving responsibilities. Furthermore, significant gaps in health information, stemming from biases in research and data collection, continue to hinder the development of targeted interventions that adequately address women's health needs. Policymakers must adopt a holistic approach that goes beyond access to care and addresses the structural, economic, and informational barriers that perpetuate gender inequities in healthcare. By recognising the multifaceted nature of the gender health gap, targeted interventions can be designed to promote equitable healthcare outcomes for all women across the UK.

4. MOVING FORWARD: POLICY RESPONSES AND THEIR LIMITATIONS

The Women's Health Strategy for England (16) seeks to close the gender health gap by addressing socioeconomic, behavioural, and systemic factors that contribute to persistent disparities in healthcare access and outcomes. While financial constraints were historically a significant barrier, evidence suggests that other structural and cultural factors continue to limit women's ability to access timely and appropriate healthcare. This strategy attempts to mitigate these challenges through targeted interventions across multiple dimensions of healthcare policy and service delivery.

This analysis maps the Women's Health Strategy to these three primary causes of gendered health inequalities – socioeconomic, behavioural, and systemic barriers—to evaluate the comprehensiveness of its approach. It further assesses the strategy in relation to the underlying factors that lead to these disparities, examining whether the proposed measures sufficiently address the structural constraints that contribute to gendered differences in healthcare access and outcomes.

SOCIOECONOMIC FACTORS

Socioeconomic inequalities, including financial instability, caregiving responsibilities, and rigid workplace policies, create significant barriers to healthcare access. Women in lower-income groups often experience greater health needs yet have fewer opportunities to seek care, particularly due to constraints in taking time off work. Globally, inadequate access to menstrual products and hygiene facilities further exacerbates economic disadvantages, contributing to absenteeism and reduced participation in work and education.

To address these barriers, the strategy promotes improved workplace policies, advocating for flexible working arrangements and employer-led support for menopause and pregnancy-related health concerns. By encouraging the development of women-friendly workspaces, the strategy aims to reduce the opportunity costs associated with seeking medical care.

Expanding community-based services through women's health hubs is another key initiative designed to improve access for underserved populations, ensuring that healthcare delivery accounts for both geographic and financial disparities. Additionally, recognising that women experience mental health conditions at disproportionately high rates (especially in consideration of the mental health consequences in the post-partum period (16), the strategy calls for integrating gender-specific considerations into mental health policies by expanding access to targeted psychological and psychiatric services.

Despite these efforts, the voluntary nature of employer-led health policies may result in uneven adoption, particularly in sectors where women are overrepresented in low-wage or precarious employment. Without legislative enforcement, workplace flexibility and health accommodations may remain inaccessible to many women. The effectiveness of community-based services is also contingent upon long-term public health funding and workforce availability, both of which remain uncertain. Following reports that the funding for these women's health hubs may be removed, Royal College of Obstetricians and Gynaecologists (RCOG) have written

DOI: 10.31389/lseppr.122

to the secretary of state for health and social care advising against this move, citing the considerable impact it has already had where implemented.

Additionally, the strategy does not fully account for the intersectionality of gender, income, and ethnicity, leaving certain vulnerable groups at risk of continued exclusion from essential healthcare services. Small businesses and industries with limited financial flexibility may struggle to implement comprehensive workplace health support programmes, further entrenching disparities. Policies designed to expand community healthcare must include targeted outreach to ensure equitable access, particularly for women in rural or socioeconomically disadvantaged areas.

BEHAVIOURAL FACTORS

Cultural and behavioural norms significantly shape women's health-seeking behaviour, often discouraging timely medical intervention. The strategy promotes public awareness campaigns and health literacy initiatives aimed at normalising preventative healthcare and routine screenings. Encouraging women to proactively manage their health through education and outreach programmes is intended to counteract stigma and increase engagement with available healthcare services.

Additionally, workplace-based health initiatives aim to create an environment where women feel supported in seeking medical care without fear of professional repercussions. Policies that expand access to occupational health services and reinforce protections against discrimination are expected to improve healthcare access and reduce stigma-related delays in seeking treatment.

Misinformation and cultural stigma surrounding women's health conditions remain deeply embedded, limiting the impact of awareness campaigns. While health literacy initiatives are a step forwards, they may not sufficiently address barriers in marginalized communities where language, education levels, and economic constraints further limit engagement with healthcare. Without robust enforcement mechanisms, workplace interventions may fail to protect women in industries with high job insecurity, where taking time off for health concerns is perceived as a liability.

Care delivery that reflects sex- and gender-specific needs is essential for improving health outcomes. Public health programmes must be designed with gender-informed perspectives, acknowledging how social expectations, stigma, and caregiving burdens affect access to healthcare.

SYSTEMIC FACTORS

Gender disparities in healthcare are reinforced by historical male-centric biases in medical research, underinvestment in women's health, and gaps in healthcare system design. Women have been chronically underrepresented in clinical trials, leading to significant gaps in understanding female-specific conditions and differential treatment responses. Additionally, the fragmented delivery of healthcare services often results in delayed diagnoses and treatment for conditions such as endometriosis, PCOS, and cardiovascular disease.

To address these systemic barriers, the strategy advocates for the expansion of women's health hubs, providing integrated care that reduces diagnostic delays (17) and ensures that female-specific conditions receive appropriate medical attention. Investment in gender-specific medical research is also a key priority, aiming to close knowledge gaps in treatment effectiveness and disease progression among women.

The strategy further outlines governance and accountability measures, introducing a cross-government delivery board to oversee implementation and track progress. Strengthening preventative care initiatives, such as one-stop clinics for contraception management, cervical screening, and specialised treatment for female-specific conditions, is another critical component.

The effectiveness of women's health hubs is highly dependent on sufficient funding and workforce capacity, both of which remain constrained. Furthermore, while centralized hubs improve access for many women, they may inadvertently exclude those with mobility challenges

DOI: 10.31389/lseppr.122

or caregiving obligations. Complementary outreach efforts, such as mobile health units and telehealth solutions, are necessary to ensure equitable access for all women, regardless of geographic or socioeconomic status.

The reliance on existing healthcare data infrastructure is another limitation, as gendered health disparities are not systematically tracked. Without comprehensive gender-disaggregated data collection, evaluating the impact of these interventions and identifying remaining gaps will be challenging.

To improve women's health outcomes, investment in research, data, and service delivery must be sustained and systematically integrated into the broader healthcare framework.

More funding is needed to advance biological understanding and improve diagnostics for female-specific conditions. Strengthening the systematic collection, analysis, and reporting of gender-disaggregated health data will allow for more accurate representation of women's healthcare needs. Expanding women-centric research across all stages of clinical development and medical research is essential to address historical knowledge gaps.

Ensuring that comprehensive women's healthcare services are integrated into all levels of care will improve outcomes from prevention through to treatment. Creating financial incentives for investment in women's health innovation can drive sustainable improvements in healthcare delivery.

The strategy provides an important foundation for improving women's health, but its long-term success will depend on the extent to which systemic gaps in funding, research, and healthcare delivery are addressed. A multifaceted approach integrating policy reforms, sustained investment, and gender-responsive service delivery is necessary to ensure that healthcare systems effectively meet the needs of all women, regardless of socioeconomic background or life circumstances.

5. CONCLUSION

The gender health gap in the United Kingdom remains a significant public health and economic concern, reflecting systemic inequities in healthcare access and outcomes between men and women. Despite women reporting higher morbidity levels across a range of conditions compared to men, healthcare systems have historically been structured around male-centric models, leading to diagnostic delays, suboptimal treatment, and unmet healthcare needs for women. The existing literature underscores that while women demonstrate greater health-seeking behaviour, structural, and socioeconomic barriers – such as financial constraints, caregiving responsibilities, and workplace policies – continue to impede their ability to access timely and appropriate care. Moreover, women from lower socioeconomic backgrounds and marginalized communities experience compounded health inequities, highlighting the intersectionality of gender, income, and ethnicity in shaping health outcomes.

The Women's Health Strategy for England represents a comprehensive policy response aimed at addressing these disparities through targeted interventions across multiple domains. Key initiatives include the establishment of women's health hubs to provide integrated and specialised care, the expansion of preventive screening programmes, and the development of gender-sensitive mental health support. Furthermore, the strategy emphasises the importance of workplace reforms, such as flexible working arrangements and employer training, to better accommodate women's health needs and to reduce the stigma surrounding conditions such as menopause and menstrual health. In addition, efforts to bridge data gaps and promote gender-specific medical research aim to enhance the evidence base and to drive more informed healthcare policy decisions.

In spite of its ambitious scope, the strategy faces several limitations that may hinder its effectiveness in closing the gender health gap. A critical challenge lies in the voluntary nature of many employer-led initiatives, which may result in inconsistent implementation across different sectors and industries. Additionally, the strategy's emphasis on healthcare service provision, while important, does not fully address the structural determinants of women's health, such as the burden of unpaid caregiving responsibilities and economic insecurity. Furthermore, the reliance on existing data sources may limit the strategy's ability to capture nuanced gendered

health experiences, necessitating further investment in gender-disaggregated health data collection and analysis.

While the Women's Health Strategy provides a promising framework for improving women's health outcomes in the UK, addressing the gender health gap requires a more holistic and sustained approach. Policymakers must not only focus on improving healthcare access but also tackle the broader socioeconomic barriers that prevent women from utilising healthcare services effectively. Recognising that underdiagnosis and delayed treatment may exacerbate the already substantial health gap, future efforts must prioritize both structural interventions and cultural shifts to ensure equitable health outcomes for all women, regardless of their socioeconomic status or background.

COMPETING INTERESTS

The author has no competing interests to declare.

AUTHOR AFFILIATIONS

Genevieve Jeffrey orcid.org/0009-0005-2143-6967
LSE Department of Health Policy,UK

REFERENCES

1. **World Economic Forum.** Global gender gap 2024 [Internet]. Switzerland: WEF; c2024 [cited 2024 Sep 14]. Available from: https://www3.weforum.org/docs/WEF_GGGR_2024.pdf.
2. **Patwardhan V, Gil GF, Arrieta A, Cagney J, DeGraw E, Herbert ME,** et al. Differences across the lifespan between females and males in the top 20 causes of disease burden globally: A systematic analysis of the Global Burden of Disease Study 2021. *Lancet Public Health* 2024;9:e282–e294. DOI: https://doi.org/10.1016/S2468-2667(24)00053-7
3. **Avdic D, Johansson P.** Absenteeism, gender and the morbidity–mortality paradox. *J Appl Econ.* 2017;32:440–62. DOI: https://doi.org/10.1002/jae.2516
4. **Wardle J, Haase AM, Steptoe A, Nillapun M, Jonwutiwes K, Bellisie F.** Gender differences in food choice: The contribution of health beliefs and dieting. *Ann Behav Med.* 2004;27:107–16. DOI: https://doi.org/10.1207/s15324796abm2702_5
5. **Schünemann J, Strulik H, Trimborn T.** The gender gap in mortality: How much is explained by behavior? *J Health Econ.* 2017;54:79–90. DOI: https://doi.org/10.1016/j.jhealeco.2017.04.002
6. **Fryer J, Mason-Jones AJ, Woodward A.** Understanding diagnostic delay for endometriosis: A scoping review. *medRxiv*. 2024. DOI: https://doi.org/10.1101/2024.01.08.24300988
7. **Mainuddin A, Begum HA, Rawal LB, Islam A, Islam SS.** Women empowerment and its relation with health seeking behavior in Bangladesh. *J Fam Reproduc Health.* 2015;9:65.
8. **Office for National Statistics (ONS).** Unpaid care expectancy and health outcomes of unpaid carers [Internet]. England: ONS; c2024. [Released 2024 Apr 18]. Available from: https://www.ons.gov.uk.
9. **Olson MM, Alhelou N, Kavattur PS, Rountree L, Winkler IT.** The persistent power of stigma: A critical review of policy initiatives to break the menstrual silence and advance menstrual literacy. *PLOS Global Public Health.* 2022;2:e0000070. DOI: https://doi.org/10.1371/journal.pgph.0000070
10. **Warriner S, Bryan K, Brown AM.** Women's attitude towards the use of complementary and alternative medicines (CAM) in pregnancy. *Midwifery.* 2014;30:138–43. DOI: https://doi.org/10.1016/j.midw.2013.03.004
11. **Department of Health and Social Care.** Women's health strategy: Call for evidence – Outcome. DHSC; 2021 [cited 2025 Feb 17].
12. **Gorham B, Langham O.** Women's health economics: Investing in the 51 per cent [Internet]. NHS Confederation; 2024. Available from: https://www.nhsconfed.org/publications/womens-health-economics.
13. **Funding research on women's health.** *Nat Rev Bioeng.* 2024;2:797–8. DOI: https://doi.org/10.1038/s44222-024-00253-7
14. **The Lancet Digital Health.** Empowering women in health technology. *Lancet Digital Health*. 2022;4:e149. DOI: https://doi.org/10.1016/S2589-7500(22)00028-0
15. **Temkin SM, Barr E, Moore H, Caviston JP, Regensteiner JG, Clayton JA.** Chronic conditions in women: The development of a National Institutes of health framework. *BMC Women's Health.* 2023;23:162. DOI: https://doi.org/10.1186/s12905-023-02319-x

16. **Boukouvalas G, Gerozissis K, Darnaudéry M.** Prenatal stress: Implications for neurodevelopmental disorders and neurodegenerative diseases. *Prog Neuro Psychopharmacol Biol Psychiatry*. 2009;33:1199–1209.
17. **Department of Health and Social Care.** Women's health strategy for England [Internet]. UK: GOV.UK; 2022 [cited 2025 January 22]. Available from: https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#implementation-and-monitoring-progress.
18. **Institute for Health Metrics and Evaluation (IHME).** GBD Results [Internet]. Seattle, WA: IHME, University of Washington; 2024 [cited 2025 Jan 21]. Available from https://vizhub.healthdata.org/gbd-results.
19. **University College London, UCL Institute of Education, Centre for Longitudinal Studies.** *COVID-19 Survey in Five National Longitudinal Cohort Studies: Millennium Cohort Study, Next Steps, 1970 British Cohort Study and 1958 National Child Development Study, 2020–2021*. [data collection]. 4th Edition. UK Data Service; 2022. SN: 8658. DOI: http://doi.org/10.5255/UKDA-SN-8658-4

TO CITE THIS ARTICLE:
Jeffrey G. Barriers to Women in Accessing Healthcare in the UK – A Review. *LSE Public Policy Review*. 2025; 3(4): 5, pp. 1–12. DOI: https://doi.org/10.31389/lseppr.122

Submitted: 22 October 2024
Accepted: 18 February 2025
Published: 14 March 2025

COPYRIGHT:
© 2025 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC-BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See http://creativecommons.org/licenses/by/4.0/.

LSE Public Policy Review is a peer-reviewed open access journal published by LSE Press.