The Gender Data Gap in the NHS: Assessing the Women's Health Strategy

by Millie Chohan

King's Policy Journal

KCL Policy Research Centre

Centre for Gender Studies

Word Count: 1512

January 2026

The Gender Data Gap in the NHS: Assessing the Women's Health Strategy, by Millie Chohan

Introduction

In 2022, the UK government published the Women's Health Strategy (WHS) to tackle long-standing inequalities in women's health and make the healthcare system more responsive to women and girls. For many years, women have faced delayed diagnoses, a lack of attention to reproductive and menopause-related conditions, and a system that is largely based on male-focused research and clinical practice. These problems have created gaps in NHS data and limited understanding of how conditions such as cardiovascular disease, dementia, mental health issues, and reproductive disorders affect women.

Groups who do not fit into simple binary categories, including trans and non-binary people with female reproductive organs, are also often missing from health data and policy planning. This piece examines the gender data gap in the NHS, explores the consequences for health outcomes, and assesses how the Women's Health Strategy addresses or fails to address these inequalities. It also considers intersectional factors such as ethnicity, disability, and socioeconomic disadvantage, and offers recommendations to improve data collection so that the WHS leads to meaningful improvements in care for all women, trans, and non-binary individuals.

Policy Overview and Context

The Women's Health Strategy was introduced in 2022 to address the long-standing pattern of women and girls in the UK spending a greater proportion of their lives in poor health than men, despite generally living longer (Women's Health Strategy, 2022). The Strategy identifies several structural failings that contribute to this disparity. Women's health needs, such as menopause, menstrual health, miscarriage, and other reproductive concerns, have often been sidelined in policy, service design, and clinical education (Women's Health Strategy, 2022). This neglect is reinforced by the under-representation of women in clinical research, which has limited understanding of conditions that affect women specifically, as well as how conditions shared by both sexes, like cardiovascular disease, manifest differently (Peters et al., 2025; Women's Health Strategy, 2022).

The government's call for evidence highlighted the scale of the problem: 84% of respondents reported that they did not feel listened to within the healthcare system (Women's Health Strategy, 2022). As a result, gaps in NHS data persist, particularly in areas such as endometriosis, cardiovascular disease, dementia, and mental health, making it harder to design services that reflect women's lived experiences (Hirst, 2022; Data Saves Lives, 2022). These gaps also translate into practical barriers, such as women having to navigate multiple services to meet basic reproductive health needs or struggling to access routine care like contraception (Women's Health Strategy, 2022). Although the Strategy acknowledges that experiences vary across groups, its commitments are uneven. It briefly notes that

transgender men and non-binary people with female reproductive organs should still receive relevant screening and symptom information, but they are otherwise largely absent from the document (Women's Health Strategy, 2022; Stonewall, 2021). Similarly, while it recognises the need for more research into conditions such as fibroids, which disproportionately affect women of African and Caribbean heritage, there is limited detail on how wider ethnic, social, or economic disparities will be addressed through data or service reform (Women's Health Strategy, 2022).

The Gender Gap in NHS Care Systems

Significant gaps in gender-specific health data persist across the NHS, shaping both research and service provision, and influencing how the Women's Health Strategy can be implemented. Women are under-represented in clinical trials, meaning that much medical evidence, ranging from cardiovascular disease to general diagnostics, is based predominantly on male research, resulting in misdiagnoses and delayed treatment for women (Peters et al., 2025; Women's Health Strategy, 2022). Conditions that primarily affect women, such as endometriosis and menopause-related health issues, remain under-researched (Women's Health Strategy, 2022).

The NHS collects patient data through routine care systems, shared care records, digital tools, and programmes such as the GP Data for Planning and Research, and links individuals using NHS numbers (Peters et al., 2025; Data Saves Lives, 2022). However, current systems still lack comprehensive and intersectional breakdowns, leaving gaps in data for ethnicity, disability, and gender identity (Data Saves Lives, 2022; Stonewall, 2021). These limitations constrain the Women's Health Strategy's ability to target interventions effectively, as policymakers cannot fully identify or monitor inequalities across overlapping vulnerabilities (Peters et al., 2025).

Trans and non-binary people with female reproductive organs are explicitly recognised in the Women's Health Strategy for cancer screening, yet broader NHS data collection does not routinely capture gender identity, leaving much of this population invisible in planning and monitoring (Stonewall, 2021; Women's Health Strategy, 2022). This invisibility, combined with reliance on male-focused research and insufficient datasets, risks undermining the policy's goals of improving care, tailoring services, and addressing systemic health inequities for all women.

Why the Gender Gap Matters

The lack of comprehensive, intersectional health data has direct consequences for women, trans, and non-binary people. For women, male-focused clinical research contributes to misdiagnoses in conditions such as lupus, rheumatoid arthritis, and neurological and mental health conditions, where symptoms present differently than in men, delaying treatment and increasing risk of poor outcomes (Peters et al., 2025; Women's Health Strategy, 2022).

Similarly, under-researched conditions like endometriosis and menopause lead to long diagnostic delays, inadequate treatment, and reliance on ineffective or inappropriate interventions

(Women's Health Strategy, 2022). For trans and non-binary people with female reproductive organs, invisibility in NHS data results in gaps in tailored care. With only limited recognition in the Women's Health Strategy for cancer screening, broader health needs remain unmonitored, leaving many at risk of poor outcomes (Stonewall, 2021; Women's Health Strategy, 2022).

Intersectional inequalities for women from ethnic minority backgrounds, those with disabilities, or those facing socioeconomic disadvantage continue to shape barriers to care, yet the NHS's current lack of sufficient data prevents policymakers from identifying and addressing these overlapping vulnerabilities (Data Saves Lives, 2022; Women's Health Strategy, 2022). Without accurate and inclusive data, the Women's Health Strategy risks basing interventions on incomplete evidence, limiting its ability to improve health outcomes equitably and perpetuating the systemic inequities it seeks to address (Peters et al., 2025).

Discussion and Recommendations

Addressing the gender data gap is essential for the Women's Health Strategy to achieve its stated aim of improving health outcomes for women and girls and tackling long-standing inequities (Women's Health Strategy, 2022). A feminist and intersectional approach to data collection would ensure that the Strategy can move beyond broad binary data and accurately reflect the diversity of women's lives, including overlapping factors such as ethnicity, disability, and gender identity (Data Saves Lives, 2022; Stonewall, 2021). Without this, interventions risk being generic and failing to reach those most affected by health disparities.

The NHS should prioritise the routine collection and publication of inclusive, disaggregated data. This would allow the Strategy to monitor progress and identify areas where inequalities persist, for example for Black and African-Caribbean women at higher risk of fibroids or for trans and non-binary people with female reproductive organs who are currently largely invisible outside cancer screening initiatives (Stonewall, 2021; Women's Health Strategy, 2022). Health research funding should explicitly include gender diversity, ensuring that clinical trials and studies are representative and reduce the historical male-centred bias that contributes to misdiagnosis and delays in care (Peters et al., 2025; Women's Health Strategy, 2022).

The Strategy also highlights professional training and patient engagement. Integrating intersectional training for NHS staff would help ensure that improvements in clinical practice reflect real-world experiences, particularly for those whose needs have been overlooked, such as women with complex care needs or trans and non-binary patients (Stonewall, 2021; Women's Health Strategy, 2022). Strengthening collaboration with advocacy organisations, including Stonewall and community health networks, would provide practical expertise to support service design, monitoring, and evaluation in line with the Strategy's priorities (Stonewall, 2021).

Practical challenges remain. Expanding data collection could raise privacy concerns, increase bureaucratic complexity, and face political resistance. However, applying feminist and intersectional

principles would enable the Women's Health Strategy to use high-quality, representative evidence to guide interventions, ensuring that services are inclusive, responsive, and equitable. By embedding these approaches, the Strategy can move from an aspirational policy statement to concrete improvements in care for all women, trans, and non-binary people, fulfilling its goal of addressing historical injustices in the NHS (Women's Health Strategy, 2022).

Conclusion

The Women's Health Strategy is an important step towards recognising and addressing gender inequalities in health. However, ongoing gaps in NHS data, including the under-representation of women in clinical research and the lack of intersectional and gender-diverse information, limit how effective the strategy can be. These gaps contribute to misdiagnoses, delayed treatment, and inadequate services for women, while trans and non-binary people with female reproductive organs remain largely invisible outside targeted screening programmes.

To achieve the aims of the WHS, the NHS needs to prioritise inclusive, disaggregated data collection, intersectional training for health professionals, and closer collaboration with advocacy groups so that policy decisions are based on comprehensive and representative evidence. If feminist and intersectional approaches are built into data collection and service planning, the strategy can move beyond ambitious rhetoric and support more equitable and responsive care that tackles historical inequalities and improves health outcomes for all women, trans, and non-binary people.

Bibliography

BMJ. (2022). Representation of women in clinical trials: Implications for diagnosis and treatment. BMJ. Retrieved from https://www.bmj.com/content/377/bmj-2022

Peters, S. A. E., Graham, B. M., Berwanger, O., Harris, K., Woodward, M., & Hirst, J. E. (2025). Innovative design and modelling to improve sex and gender analysis in clinical trials. BMJ, 391, e085681. Retrieved from https://www.bmj.com/content/391/bmj-2025-085681

NHS England. (2022). Women's Health Strategy for England. Retrieved from https://www.england.nhs.uk/publication/womens-health-strategy-for-england-2022/

NHS England. (2022). Data Saves Lives: Reshaping health and social care with data. Retrieved from https://www.england.nhs.uk/publication/data-saves-lives/

Stonewall. (2021). The experiences of LGBT people in healthcare in Britain. Retrieved from https://www.stonewall.org.uk/lgbt-health-report