Editorials

The triple E:

Equality, Equitable health care, and Empowerment — are we there yet?

'One never notices what has been done; one can only see what remains to be done.'[1]
Marie Curie

As a woman with a complex chronic illness, I understand the complexities surrounding the delay in improving health care for women. I believe primary care plays a vital role in promoting women's health as acute clinicians are involved in the treatment pathway much later. Early diagnosis and effective long-term clinical management using personalised approaches should be considered as routine practice. For centuries, women have lived in a male-dominated society. Thus, it is unsurprising that healthcare systems, mostly designed by men, lack equitable and personalised care suited to women,[2] as health conditions affect men and women differently. While many discuss continuous improvement and quality of care for women, there is still a lack of knowledge base in terms of gender-to-disease specificity. The term 'women's health' is often considered as gynaecology and obstetrics conditions. This perception has led to a variety of complications around emphasising the need for change in women's health research, funding, and models of care in primary and secondary care, which often act as barriers for progress.

WOMEN'S HEALTH STRATEGY

On 8 March 2021, the UK Government launched a consultation to develop England's first Women's Health Strategy, with a view to developing a healthcare system that listens, empowers and improves clinical approaches to managing women's overall health in a more integrative manner.[3] Independent inquiries and reports, including the Independent Medicines and Medical Devices Safety Review,[4] as well as the report raised by Ian Paterson,[5] have demonstrated that our current healthcare system fails to keep women safe and that there is a need for active listening when concerns are raised by female patients. This became a catalyst for change that led to over 100 000 women like myself being part of the current consultation to help transform our valuable healthcare system to one that is able to evolve with the changing needs.[6]

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Central to the Women's Health Strategy is providing optimal care throughout the lifecourse, which would mean disease-orientated approaches focusing on a single condition at a particular life stage would be a thing of the past.

The UK population is approximately 68 million, with women making up almost 51%.[3] Of this, 72% of women are between the ages of 16–64 years and are actively part of the UK's workforce.[3] This would mean that there would only be socioeconomic gain if improvements were made to a woman's health. Common health conditions such as endometriosis, cancer, cardiovascular disease, metabolic disorders, rheumatological conditions, pre-eclampsia, gestational diabetes, menopause, adenomyosis, and chronic pelvic pain contribute to the loss of a woman's wellbeing and overall quality of life.

The complex long-term symptoms of these conditions associated with medication use could further contribute to a decline in a woman's overall wellbeing, including impact on their personal relationships.

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Challenges such as adherence to medication for chronic illnesses, ongoing clinical management, delayed diagnosis, and geographical variability, which all influence a woman's life expectancy, and disparities between different ethnicities, experiences, access to health care, and healthcare outcomes lead to long-term sociological issues around wellbeing, self-care, and financial independence. For many women, this comes in the form of having a stable personal and professional life.

In the UK, the proportion of women working for the NHS and social care alone is reported to be 77% and 82%, respectively.[3] Limitations in managing women's health would therefore have a negative impact on their ability to maintain financial independence and career advancement. Equally, the lack of support made available by employers could further purport to suboptimal productivity and poor job satisfaction. Some women may be forced to change careers to achieve their professional goals due to the lack of flexible working options. Also, women may be unable to obtain promotions in the workplace or sustain senior leadership positions leading to more women leaving the workforce entirely. In turn, this would have a negative impact on the UK economy.

An important facet to address barriers would be to minimise stereotypical issues, limitations in comprehensive multicare level research, longitudinal healthcare outcomes, and reduce use of existing clinical data from electronic healthcare record systems. This can be improved by way of utilising five primary categories within clinical medicine: surveillance; deep medicine; digital health; preventative medicine; and integrative medicine. Surveillance has primarily focused on communicable diseases, although this could be used for common non-communicable diseases such as coronary artery disease. Deep medicine drives evidence-based medicine and practices forward allowing existing clinical and research data to be used in

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a more comprehensive manner. These two components could lead to improving preventative strategies for a variety of health conditions, including cancers, and the development of medications such as gene therapies. This is equally important to promote integrative medicine approaches where disease sequelae is considered as part of chronic condition management plans. Digital health care would act as the facilitative plug.

WOMEN'S HEALTH RESEARCH

To truly implement the new Women's Health Strategy it is vital to understand the change in a rapidly evolving healthcare system. This could be a daunting prospect for overstretched primary and acute services. Thus, solutions to this issue are complex in nature, especially those around funding and resources. The use of digital technologies could assist as a first step to demonstrate knowledge and practice gaps across an array of clinical conditions among women. Existing electronic healthcare data could be used to maximise the understanding of disease prevalence, incidence, and management. Lifecourse epidemiology research, for example, could add value to the overall clinical and patient-reported outcomes.

Addressing the available funding landscape to motivate researchers and clinicians alike could also promote the development of a better women's health research portfolio nationally, as primary care research at present does not drive women's health research in the UK. To address this as a priority, perhaps the National Institute for Health Research, Department of Health and Social Care, higher education institutions, and Royal Colleges should discuss developing priority areas aligned to the needs of women. For example, improved diagnoses timelines and management of disease sequelae and/or multimorbidity, in addition to early intervention approaches to improve intergenerational outcomes, could be useful. This is particularly important in cardiovascular disease.

Similarly, patient advocates should be more involved with patient–public components when developing studies and funding applications from the perspective of study design, development, conduct, and implementation research. An array of phenomenal women want to spearhead the transition of clinical research to clinical practice but there is a paucity of such opportunities. Similar approaches have been endorsed by the World Health Organization and the Royal College of Obstetricians and Gynaecologists, and published as part of their report, *Better for Women*.[7] Wider changes are needed in a more joined-up manner between primary and secondary care services. Hence, changes to healthcare systems should be led through discussions with female patients.

As a patient, I would urge GPs, consultants, and clinical researchers to better understand the healthcare needs of women, and implement remedial action. The importance of listening to a patient should be at the heart of this change, along with transparency.

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