How to navigate health and social care policy: the influence of politicisation and discourse

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About us

Dr Catherine Marchand, PhD, MBA

- I joined CHSS in September 2015. Coming from a background in social psychology and organisational behaviour, my previous research has explored interprofessional collaboration in health and social care
- My research interests are
    - Health and care workforce wellbeing, inc. occupational stress, health psychology, and employee well-being
    - Lived experience of health and care professions and care
    - Mixed-method research, systematic review

- Recent and future research projects include
    - Skill mixed in general practice
    - Exploration of the rural and coastal curriculum in two medical schools
    - Gendered medicine in chronic pain; an interdisciplinary workshop looking at the 'recent' history of chronic pain, a clinical pain specialist and the lived-experience of pain
    - Policy and inequalities in health and care

Dr Simon Fletcher, PhD, MA

- I joined CHSS as a Research Fellow in August 2022. Coming from a background in social sciences a great deal of my previous research has explored interprofessional collaboration in health and social care.

- Having undertaken a PhD in sociology at Manchester Metropolitan University, in 2015 I joined the Department of Health and Social Care at Kingston and St Georges University. I contributed to a number of projects during my time there, and these were mostly focussed around professional interaction across a range of health and social care contexts. I most recently co-led a NIHR funded study which conducted a realist synthesis of literature which explored leadership in integrated care teams and systems

- Research interests include:
    - Sociology, including post-structural and late modern theory
    - Interprofessional collaboration, including professional and organisational tension and barriers to successful coordination,
    - Qualitative inquiry; Systematic reviewing; Realist syntheses and evaluation

Discussion – 10 mins

- In small groups, discuss the extent to which your experience (professional/personal) has been influenced by politics
- Think about how prevalent politically and socially embedded narratives have contributed to specific contextual outcomes

What is politicisation?

- Health and social care policy in the UK is fundamentally political
- It is impossible to separate political influence from health and social care provision
- Subsequently, prevailing discourse, embedded in political ideology contributes to inequality, conventional narratives and enables dominant perceptions, **based on beliefs**
- Terminology such as *Diversity and Inclusion* for example have become rhetorical devices
- Should or can health and social care be regarded with neutrality?

Health and Care Act 2022

Sex and gender

Example 1

Equality Act – Sex and Gender (reassignment) – Updates [1]

Sex

- A man or a woman

Clarification to be added following the ruling of the Supreme Court.

- A ‘woman’ is a biological woman or girl (a person born female)
- A ‘man’ is a biological man or boy (a person born male)

If somebody identifies as trans, they do not change sex for the purposes of the Act, even if they have a Gender Recognition Certificate (GRC).

- A trans woman is a biological man
- A trans man is a biological woman

Equality Act – Sex and Gender (reassignment) – Updates [2]

What about people born intersex?
1% American, 2% worldwide. “[u]p to 1.1 million people in the UK alone. Being intersex is as common as being a twin” (Richmond, 2021)

“People who are intersex have reproductive or sexual anatomy that doesn’t fit into an exclusively male or female (binary) sex classification. Intersex traits might be apparent when a person is born, but they might not appear until later (during puberty or even adulthood). You may never notice their intersex traits externally, and you might only find out about them after a surgery or imaging test.

In the past, being intersex was known as having a disorder of sex development (DSD), and you might see it referred to this way in some places. But being intersex isn’t a disorder, disease or condition. Being intersex doesn’t mean you need any special treatments or care.
Being intersex may affect your:

- Genitals: Ovotestes (both ovarian and testicular tissue), presentation of external male genitals with internal reproductive anatomy or hormone levels associated with being female.
- Chromosomes: XX, XY, XXY, Mixed of XX and XY cells, or X0
- Hormones.
- Reproductive system.
- Gonads (ovaries or testicles).” (Cleveland Clinic)

Equality Act – Sex and Gender (reassignment) – Updates [3]

Gender reassignment

1) A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.
2) A reference to a transsexual person is a reference to a person who has the protected characteristic of gender reassignment.
3) In relation to the protected characteristic of gender reassignment—
   a) a reference to a person who has a particular protected characteristic is a reference to a transsexual person;
   b) a reference to persons who share a protected characteristic is a reference to transsexual persons.

"Equality Act 2010, **Changes to legislation:**
There are currently no known outstanding effects for the Equality Act 2010, Section 7.

EHRC is updating their guidance following the Supreme Court ruling in For Women Scotland v Scottish Ministers.
25th April 2025: interim report was published
30th June 2025: End of consultation following the ruling - standby

What the government said in 2018:

Government Equalities Office

TRANS PEOPLE IN THE UK

What is trans?

Trans is a general term for people whose gender is different from the gender assigned to them at birth. For example, a trans man is someone that transitioned from woman to man. Trans people do not feel comfortable living as the gender that they were born with. They take serious, life-changing steps to change their gender permanently.

What is a gender change?

Changing gender involves social, medical, legal and administrative changes. Trans people can change their name and gender for almost all services without changing their legal gender. This includes passports and driving licences.

How many trans people are there?

We don't know. No robust data on the UK trans population exists. We tentatively estimate that there are approximately **200,000-500,000** trans people in the UK. The Office for National Statistics is researching whether and how to develop a population estimate.

Facts and Figures

41% of trans men and trans women responding to a Stonewall survey said they had experienced a hate crime or incident because of their gender identity in the last 12 months. They also found that **25%** of trans people had experienced homelessness at some point in their lives. Our national LGBT survey found similar results, with **67%** of trans respondents saying they had avoided being open about their gender identity for fear of a negative reaction from others.

How can you legally change your gender?

Trans people can change their legal gender by meeting the requirements set out in the Gender Recognition Act 2004. They then receive a Gender Recognition Certificate, by which their birth certificate is changed. The requirements are:

1. A medical diagnosis of gender dysphoria
2. A report from a medical professional detailing any medical treatment
3. Proof of having lived for at least two years in their acquired gender through, for example, bank statements, payslips and a passport
4. A statutory declaration that they intend to live in the acquired gender until death
5. If married, the consent of their spouse
6. Payment of a fee of £140 (or proof of low income for reduction/removal of the fee)
7. Submission of this documentation to a Panel, which the applicant does not meet in person

How many people have changed their legal gender?

Since the Act came into force, **4,910** trans people have been issued a Gender Recognition Certificate. **12%** of trans respondents to the National LGBT survey who had started or completed their transition had successfully obtained one, and **7%** of those who knew about them but did not have or had not applied for one said they would *not* be interested in obtaining one.

What steps are involved in a gender transition?

1 Names and pronouns on letters and utility bills 2 Gender for service providers including banks 3 Gender for employers and monitoring surveys 4 Gender in passports and driving licences	The individual makes these changes to their own accounts / documents	NOT regulated by the Gender Recognition Act 2004
5 Diagnosis of gender dysphoria, access to cross-sex hormones (from 16) and surgery (from 18)	The NHS decides	
6 A new birth certificate for marriage and right pension provision	The Gender Recognition Panel considers the application	Gender Recognition Act 2004

Consultation on the Gender Recognition Act 2004

The Government is launching a public consultation on how to best reform the Gender Recognition Act 2004. We want to know how to make the legal gender recognition process less bureaucratic and intrusive. No final decisions have been made on what reform will look like but we have made some decisions about what is not within the scope of these reforms. We are also aware that there are some misunderstandings about what reform of the Gender Recognition Act might include. Therefore, we want to provide clarity on some issues that are frequently raised.

1 There will be no change to the provision of women-only spaces and services

The Government is clear that there will be no change to the Equality Act 2010, which allows service providers to offer separate services to males and females, or to one sex only, subject to certain criteria. These services can treat people with the protected characteristic of gender reassignment differently, or exclude them completely, but *only* where the action taken is a proportionate means of achieving a legitimate aim. Importantly, a service provider's starting point should be to treat a trans person in the gender they identify with, and to allow them to access services for that gender *unless* by doing so they would be unable to provide that service to other service users. This means it can't be a blanket ban, or done on a whim. It has to be for a real reason, on a case by case basis. For example a female only domestic violence refuge may provide a separate service to a trans woman if it can be shown there is a detriment to other service users from including the trans woman as part of the regular service. If they then have to exclude that trans person, they ought to consider what alternatives they can offer to the trans person. This has been the law since 2010 and will not change.

2 There will be no change to the NHS medical pathways for trans people

Many trans people seek medical treatment provided by the NHS. Trans people require a diagnosis of gender dysphoria before receiving any treatment. The medical pathways are not regulated by the Gender Recognition Act, but by the NHS. As a result, reform of the Act will not influence the medical steps that trans people need to go through for their medical transition under the NHS.

3 Children are not put at risk

Reform to the Gender Recognition Act will not change the **legal** rights of trans children. The minimum age for legal gender recognition is 18, aligned with the full rights and responsibilities of adult citizenship, and the Government has no intention of changing this. We have also said that the Equality Act 2010 provisions will not change. As a result, existing arrangements of separate sex facilities, like toilets, changing rooms, and communal accommodation on school trips will not change. The age for accessing **medical** NHS gender identity treatment is decided on by the NHS, not the Gender Recognition Act. Surgical treatment is not available to people under 18. Cross-sex hormones are available to those aged 16 and above under guidance. Trans minors only receive treatment whilst receiving ongoing psychological support.

4 All views will be heard in the consultation

We acknowledge that there are many different views on reform of the Gender Recognition Act. We are committed to hearing everyone's opinion. The consultation will pose an open set of questions about possible reform. After the views are gathered, we will bring forward proposals. In our pre-consultation, we have met with many women's rights stakeholders.

5 We are committed to making the lives of trans people easier

Trans people face negative reactions to their gender identity in society and can become victims of hate crimes, domestic abuse and harassment simply because of their gender identity. Trans people already have the right to legally change their gender, and there is no suggestion of this right being removed. This consultation simply asks how best Government might make the existing process under the Gender Recognition Act 2004 a better service for those trans and non-binary people who wish to use it. This consultation, therefore, does not consider the question of whether trans people exist or whether they have the right to legally change their gender. Trans and non-binary people are members of our society and should be treated with respect.

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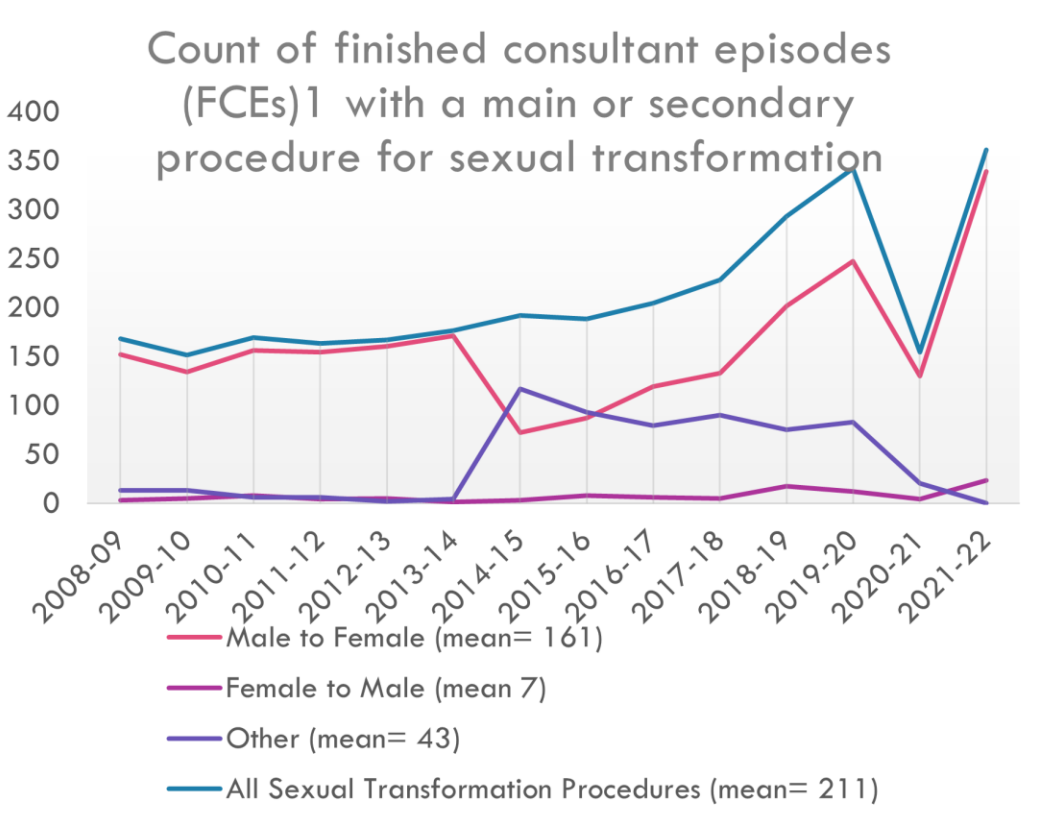
What we know?



NHS Digital (2023)

Accessible data on transgender and non-binary:

- Focus on sexual transformation and hormonal blockers
  - Lack of information about patient ages
- Information more specific for paediatric gender normalisation surgery
  - i.e. age is available

The Cass Review

- This review, conducted by Dr Hilary Cass, provided in depth insight into the current state of gender identity services for children and young people in the UK
- This was the first full review which focused on gender identity services and revealed a broad lack of high-quality evidence around specific clinical interventions
- In addition, there were reports of professional hesitancy to treat children and young people and a lack of cooperation from adult gender identity services
- Main conclusion is that the evidence is weak.

All this played out against a highly charged backdrop of public opinion:
'The surrounding noise and increasingly toxic, ideological and polarised public debate has made the work of the Review significantly harder and does nothing to serve the children and young people who may already be subject to significant minority stress' (p. 20)

Critically Appraising the Cass Report: Methodological Flaws and Unsupported Claims

Findings:

- Significant methodological and conceptual flaws
- Divergence from review protocols to exclude qualitative works
- Identification of sources of bias and unsubstantiated claims in primary research

“The Cass Report’s recommendations, given its methodological flaws and misrepresentation of evidence, warrant critical scrutiny to ensure ethical and effective support for gender diverse youth.” (p.2)

(Noone et al, [Preprinted] https://osf.io/preprints/osf/uhndk)

Why is it so important? [1]

- Inflammatory discourse by government members and policymakers
  - Sir Keir still believed that a transgender woman was a woman, the PM's official spokesman said: "No, the Supreme Court judgment has made clear that when looking at the Equality Act, a woman is a biological woman.“ (BBC, 22 April 2025)

- Difference in discourse
  - Focus on reassignment and opinion about reassignment >18 years.
  - Paediatric genital normalisation surgeries are from birth. Reflection is needed because most surgeries are completed for aesthetics.
  - 42 days to declare sex from birth = no statistics on intersex.
  - Incongruence in how regret is discussed in gender affirming care vs any other regret in any other field of medicine
  - Trans people: less than 0.55% of the population in England

- Hate crime, suicide ideation and suicide
  - Recent surge of hate crime against transgender and nonbinary people (up 11%; latest data in October 2024, reduction of 2%); The Home Office reckons this is due to comments made by politicians and the media
  - Research report on Trans Youth and suicide completed in 2024, but not published. It may be available in 2026. According to the LGBT Foundation, 45% of trans young people (aged 11-10) have tried to take their own life (The King’s Funds, 2025)

Why is it so important? [2]

- Recent change in the law
  - 16th April 2025 - Supreme Court ruling in For Women Scotland v Scottish Ministers – definitions of man and woman.
  - Will impact guidance by the Equality and Human Rights Commission AND
  - May/will impact workplaces, services that are open to the public, such as hospitals, shops, restaurants, leisure facilities, refuges and counselling services, sporting bodies, schools, associations (groups or clubs of more than 25 people which have rules of membership).
- Recent changes in policy
  - With an emergency ban by the government from 3/6/24 to 3/9/24
  - Fewer than 100 children and young people are taking puberty blockers.
  - The Equality Act can be changed without citizens having a say → on human rights
- Medical care
  - Whose voice should we listen to? Patient-centred care is for all
  - No clear evidence-based practices = difficulty to teach practices
  - Delays in accessibility of care were 18 months in 2018, now 99 months.
- Exclusion and possible erasure
  - Transman, Intersex, Nonbinary
- Impact on research
  - Policy influences research funding
  - Focusing on reassignment excludes many transgender, intersex, and non-binary people

What else happens when there's a lack of evidence? […] absence of informed knowledge, the void is too often filled with emotion, anger and anxiety (Kings Fund,2025)

Women’s health

Example 2

Women’s rights

- Recent history – last 100 years
  - Right to vote
  - Open bank accounts without signature from their dads or husbands
  - Right to abortion – last 30 years
    - With rights overturned recently in the USA
- 51% of the population

- While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men
- The health and care system has been designed by men for men. This ‘male as default’ approach has been seen in: research and clinical trials. education and training for healthcare professionals, the design of healthcare policies and services

Medicalisation of healthcare

- Obstetrics and gynaecology
  - Fertility and miscarriage: weight is on the women or birthing person
  - Evidence-based practices?: vaginal examination every 4hr during childbirth
  - Focus on 28-day cycle – errors in due date, ovulation and hormonal levels
  - Peri-, menopause and post- menopausal care

  - Language used: geriatric pregnancy; hostile uterus
  - Consent
  - Pain: hysteria or virtuous; just a little pinch!
  - Debate about abortion: Women's reproductive autonomy is at risk
- Chronic pain
- Autoimmune diseases

Evidence-based practices

Women's healthcare research network – Health Innovation Kent Surrey Sussex (March 2024)

- Midlife care for women (including all women who identify as women): 40-65 years are the less studied group
- Out of 4,450 studies only 4 studies "are in the area of menopause/postmenopausal issues"
- Lack of reliable information
- Women feel they were often
  - not believed in chronic care and pain;
  - Misdiagnosed or underdiagnosed
  - gaslighted
- Often late diagnostic in sexual health and sexual wellbeing
  - Late, with irreversible effects, diagnostic of HIV

"What does it matter if a middle-aged women gets chlamydia – she won't pass it to many people"

Women's health across the life course

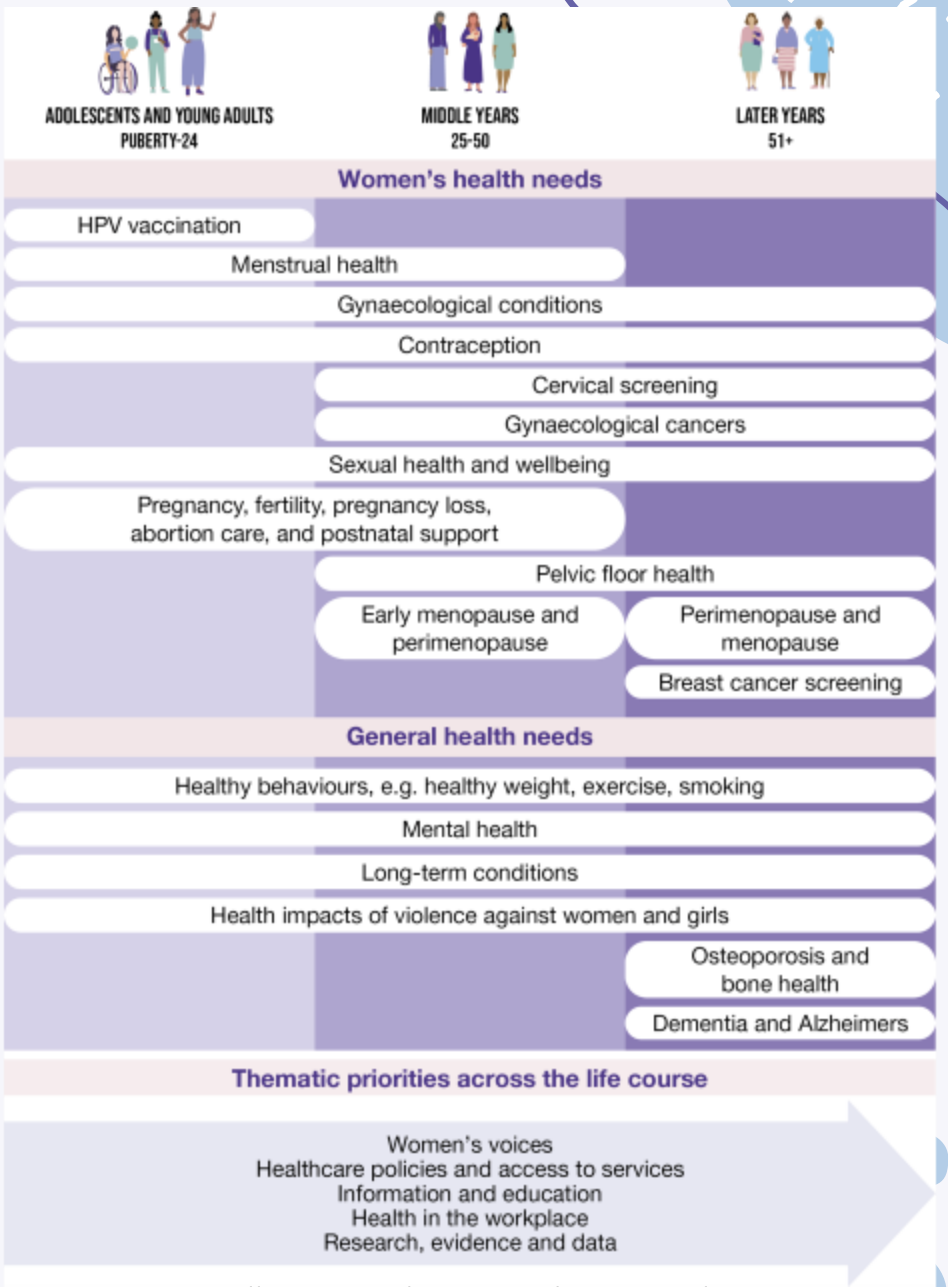
- The 'life course' approach has been informed by WHO and RCOG – comes from DHSC Women's Health Strategy paper (2022)
- Alternative to 'disease orientated' approach – instead reflects changing needs of women across their lives

- 5 priority areas suggest these have all been previously lacking

- Whilst there have been steps taken to incorporate these areas (particularly in the workplace) …

- … Interventions have often been inadequate and responsive to cultural pressure rather than rooted in developing equality

- **Contention** – the model is oversimplistic - represents androcentric/paternalistic communication of what are complex issues
- Although this model represents a change in approach it may be unlikely to fit in current systems - due to practical difficulty in accessing relevant services



https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

Discussion – 10 mins

- What is the impact of politicised ideology on:
  - Health outcomes
  - Evidence (availability/quality/development)
  - Inequalities/Inequities

- What are the risk(s) and for whom?

Discussion – 10 mins

- Do policies in your workplace reflect sex and gender equality?
- Are women's health issues given the primacy that they require?
- How have you changed practice following government policy changes?

Race and ethnicity

Example 3

Race and Ethnicity [1]

- *Despite good intentions, the structures and policies of health care organisations tend to cater for the majority of the population without adequately addressing the needs of marginalised populations who become increasingly excluded, disengaged and under-served*

(Hui et al, 2020, p. 301)

If the Equality Act is not fit for purpose, why is that? It's application or the guidance?

- Structure is designed by and for dominant/'conventional' populations
- Communities marginalised on the basis of race and ethnicity are always likely to be excluded to some extent from national policy
- Even the Equality Act (2010), which was specifically designed to address this has been deemed 'not fit for purpose' by the Fawcett Society (2018, Download.ashx (fawcettsociety.org.uk)

Race and Ethnicity [2]

- *The evidence suggesting the work of the REC falls as a burden on BME groups because it is identified as a race specific responsibility, suggests the REC will inevitably reproduce existing patterns of inequalities through the enactment of policy. The performativity and enactment of the REC become a ritual part of organisational interests; rather than addressing entrenched racial inequalities. As such, the REC framed around White normative practices performs and enacts a process in which, ' … privileges, ideologies and stereotypes reinforce institutional hierarchies and the larger system of White supremacy'*

(Bhopal and Pitkin, 2019, p. 543)

- Exploring an initiative in higher education (the Racial Equality Charter) which was directly driven by the Equality Act, Bhopal and Pitkin suggest that policy remains grounded in and dictated by dominant contexts
- Can you think of an equivalent in health and social care?

Race and Ethnicity [3]

Contention - *NHS and Govt health policy is directly and indirectly influenced by racism, leading to poorer health outcomes for communities marginalised on the basis of race*

Evidence -

- The 2020 report *Black people, racism and human rights* revealed numerous failures to implement previous recommendations within the NHS. The report recognised that the mortality of Black women during childbirth is 5 times higher compared to white women (Danso and Danso, 2021) - **Why were these recommendations not implemented?**
- Salway and colleagues (2016, p. 108) found that: *despite the apparent indications to the contrary, **ethnic equity is a peripheral concern within national healthcare policy** and is poorly aligned with other more dominant agendas … There was evidence of **significant ambivalence, and even active resistance**, to promoting this agenda among senior managers, reflected in the limited resources allocated. In contrast to other areas, such as quality and efficiency, central policy-makers have failed to articulate clear, detailed commissioning expectations in relation to ethnic diversity and equity.*
- Report from the UK Govt Commission on Race and Ethnic Disparities has also been deemed insufficient - Gopal and Rao (2021, p.1) suggest: , *it is deeply troubling that the report concludes that "**communities can take steps to improve their own health outcomes** and should be helped to do so" while failing to acknowledge the need to also tackle socioeconomic inequalities, with government leading that action*
- Culley and Demaine (2007 p. 135) suggest that health policy has lacked the depth and complex analysis required to provide an accurate explanation of health disparities attributed to differences in race and ethnicity: *Given the prevalence of essentialist discussions in the epidemiological literature, it is not unreasonable to suggest that underlying **the failure of government policy documents to discuss explanations of ethnic inequalities** in health is an **assumption that these arise as a result of genetic or cultural characteristics of minority ethnic groups**, rather than their socio-economic location*
- Robertson et al (2021, p. 17) in a King's Fund report commissioned by the NHS Race and Health Observatory suggested that key legislation has broadly failed. Stating that: (The Health and Social Care Act 2012 and The Equality Act 2010) *create a strong framework for tackling inequalities. However, in practice **there is little evidence of these having had a significant impact on the actions taken by the NHS to address ethnic health inequalities** – and legal challenges based on the NHS's duty to tackle health inequalities are very rare*.

[…]

Race and Ethnicity [4]

- *The 2018 review of the Mental Health Act found that deeply entrenched racism led to inequitable outcomes for ethnic minority communities. Even then it was clear that the Mental Health Act, designed to protect the rights of individuals, was failing to serve all groups equally, with Black people especially more likely to be sectioned under the Act, and subject to community treatment orders*. (NHS Race and Health Observatory, 2024, p. 17)

- The Mental Health Bill (2024-25) has since been developed in order to implement findings from the 2018 review.
- Whilst race and ethnicity are referred to, this generally comes under broader reference to inequalities and marginalised groups
- Why is race and ethnicity not directly responded to in legislation despite overwhelming evidence of disparities in outcome? CBP-10260.pdf

Intersectional Impacts

Discussion and conclusions

Intersectional Impacts [1]

- Although the three areas explored have specific individual challenges the interconnected disparities need to be acknowledged
- There are a range of additional forms of discrimination and subsequent outcomes that transgender and non-binary people, women and communities marginalised on the basis of race and ethnicity are subject to simply by being members of one or more of these communities
- 'Cumulative disadvantage' occurs in which multiple forms of discrimination are enacted

Intersectional Impacts [2]

- For example, the experiences of a black, trans woman are likely to be affected by more endemic and complex forms of discrimination which may result in more negative health outcomes, some of which are specific to or more prevalent in those communities
- As a society there is limited motivation to respond, understand or empathise, so effective care is unlikely to be provided
- This has not been recognised in law and policy (Xenidis, 2018) as discrimination is often reduced to a single 'protected characteristic'
- Prejudice around trans communities are almost exclusively focused on transwomen – could be linked to underlying misogyny and gendered care

Intersectional Impacts [3]

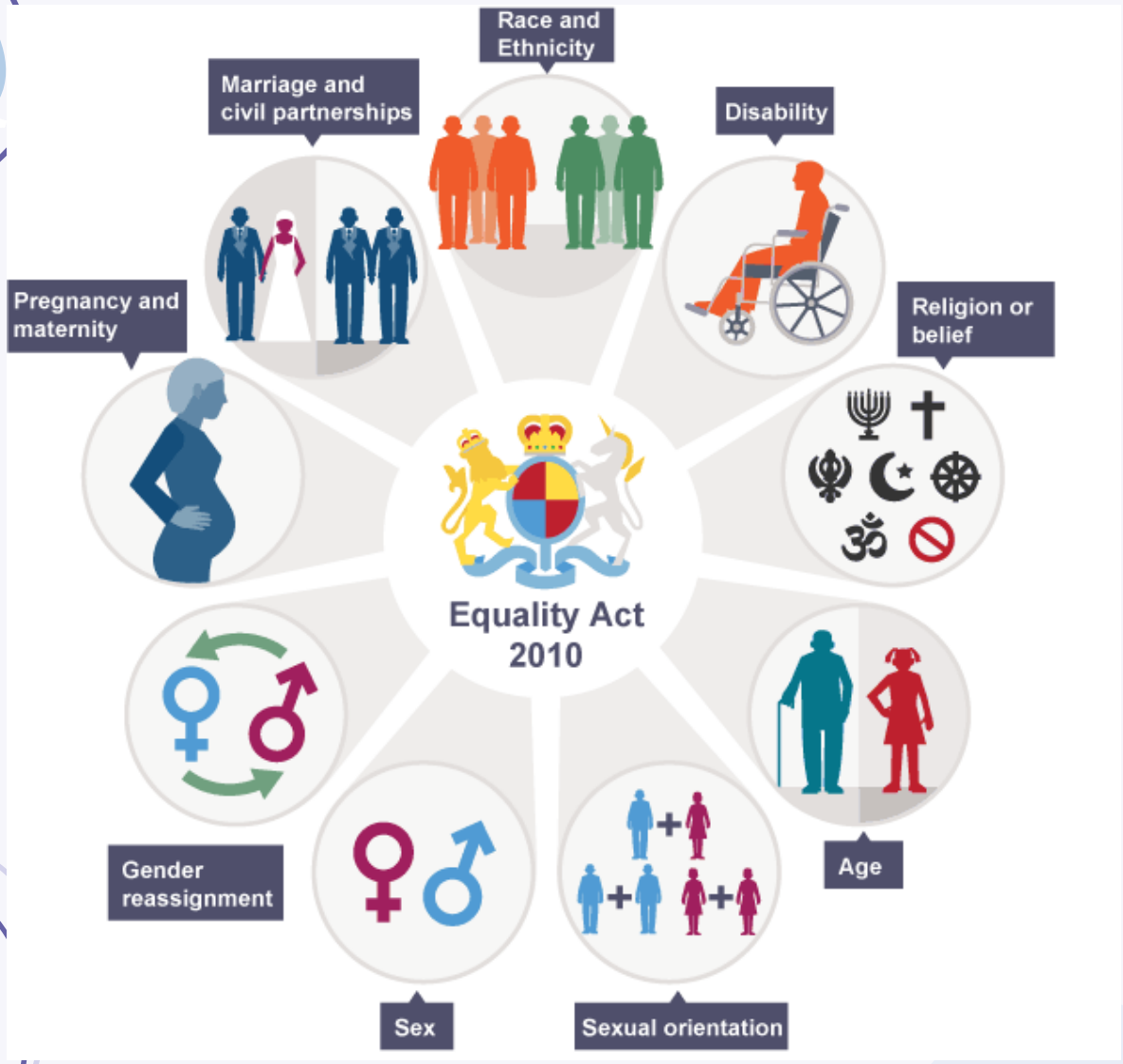
- The excerpt on the right comes from a landmark project which explored the application of intersectionality in UK policy and practice

Analysis of intersectionality's take-up, uses and meanings in equality policy documents shows that there are a range of definitions of intersectionality, and its use is largely:

- ***Individualised;***
- ***Merely descriptive;***
- ***Additive (where instead of being viewed as always shaping one another, inequalities are still viewed separately and added and subtracted from one another);***
- ***Superficial.***

The meanings and uses of intersectionality in equality policy are influenced by and also influence understandings of intersectionality among third sector organisations. While from an intersectional perspective little progress on equality will ever be made without 'doing' intersectionality, at present in the UK intersectionality is positioned as a kind of luxury that policy makers may or may not address (Christoffersen, 2021, p.12).

Intersectional Impacts [4]



Discussion

- How do we more substantially address intersectionality in health policy?
- How do we treat and deliver care to people who are subject to multiple forms of discrimination?
- What would a more appropriate and inclusive policy response look like?
- How do we reduce the impact of fear, anger, hatred, and lobbies on how we treat and care for people?
- How do we navigate *care for all, for all ages* (WHO SDGs), knowing that the politicisation of health and social care can change policies and practices and can have irreversible effects on patients?

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