HEALTH, SEX, AND GENDER INEQUALITIES:
INSIGHTS FROM SCOTLAND'S THIRD SECTOR

REPORT SUMMARY

MAY 2026

This is a concise summary of the (IN)VISIBLE report, published in May 2026, which shares insights from Scotland's third sector regarding health, sex, and gender inequalities. It explores the drivers of sex and gender-related health inequalities in Scotland, the gaps in evidence, and provides six recommendations for action.

POLICY AND LEGAL CONTEXT

The legal and policy landscape is complex and evolving. The Equality Act 2010 and the Public Sector Equality Duty set the statutory framework, but a 2025 UK Supreme Court ruling narrowed the legal interpretation of 'sex' to biological sex, creating uncertainty for how lived gender is treated in equality law. Scotland's policy environment includes the Population Health Framework, Realistic Medicine principles, the Women's Health Plan (Phase Two published January 2026), and a Gender Identity Healthcare Protocol — but implementation gaps and political uncertainty remain.

PHYSIOLOGICAL DIFFERENCES

> 'With many medicines, women are seen as 'little men' where dosage is based on the 'typical' 70kg man.'

Biological sex is a defining factor in some health experiences, including prostate, ovarian, and cervical cancers, and gynaecological conditions such as endometriosis. However, the impact of physiological differences according to biological sex on health outcomes is often poorly understood and under-researched, meaning that diagnostic pathways often reflect a 'typical male' model. This can result in delayed diagnosis, inappropriate treatment, and missed prevention opportunities. Trans and non-binary people's physiology can change with gender-affirming care, creating new screening and clinical needs that current evidence and guidance do not fully cover.

HEALTH INFRASTRUCTURE

'I think I can continue to have the private treatment until the end of the year, but if I haven't transferred to the NHS by then I'll have to sell my flat.'

NHS buildings and digital infrastructure operate on a binary gender model and can exclude or disadvantage people whose lived gender does not match those binary categories. Examples include CHI number design, screening systems, hospital wards, and waiting-list capacity for Gender Identity Clinics (GICs).

Physical spaces and wider public infrastructure, including the built environment, the housing system, and the criminal justice system, also shape gendered access to health, often reinforcing gender-related socio-economic inequalities.

'Women experience significant harms across the justice system, as victims, perpetrators of crime, and as those impacted by a family member's imprisonment. These harms are often distinct from those experienced by men and intersect with poverty and existing trauma.'

The health infrastructure determines who receives screening invitations, how safe people feel in care settings, and whether services are accessible without stigma or financial hardship.

HEALTH WORKFORCE

'Women living with several of CHSS's conditions find they are less likely to receive the treatment they need in both acute care as well as secondary and/or tertiary prevention. It may be that they can access services, but do not receive the same treatment as men.'

Workforce attitudes, training gaps and time pressures produce gendered bias in clinical care. The report documents misogyny, dismissal of women's symptoms, under-treatment of pain, and inconsistent care for trans and non-binary people.

Time constraints in the delivery health care undermine the person-centred approach required for the implementation of Realistic Medicine principles. Clinician bias and lack of knowledge regarding gender-related inequalities reduce trust, increase 'missingness', and worsen outcomes, particularly where there is a requirement for sensitive, continuity-based care (e.g., maternity, end-of-life). Community Link Workers are highlighted as a valuable mitigation of this.

SOCIETAL NORMS AND STIGMA

'There's a systemic bias against women and I think that comes from the societal expectation that women provide care, that women are automatically nurturing, that women are automatically able to not feel uncomfortable about things like providing personal care.'

Gendered social norms shape health behaviours and access to care. Women shoulder most unpaid care roles, limiting their ability to prioritise health. Men are less likely to seek help for mental health and preventative care, and trans and non-binary people face pervasive stigma that deters service use. These norms interact with service design to produce 'missingness' and unequal uptake of screening and support.

'I try to be supportive but how do you support your wife through this, where do you start. I'm not the priority here.'

INTERSECTIONAL BARRIERS

Gender intersects with age, race, disability, migration status, and sexual orientation to magnify harms. Older women experience ageism in clinical assessment; migrant and ethnic minority women face worse birth outcomes and discriminatory maternity care, disabled women face coercion or infantilisation in reproductive decisions, and bisexual women show disproportionately poor mental-health outcomes.

'There's an assumption that because you are older and you're a woman that, you know, there is going to be bits of you that are worn out and you've just got to face it.'

In addition, national datasets are often insufficiently disaggregated to reflect these intersectional inequalities. Without better disaggregated data and qualitative evidence, policy and services will miss the people most harmed by compounded inequalities. However, the third sector plays a critical role in filling evidence gaps regarding intersectional inequality.

'Not only do we have data gaps, but where we have data, particularly when you're talking about disaggregated data, it is not statistically significant enough for us to base anything on it.'

RECOMMENDATIONS

The report sets out six recommendations aimed at Scottish Government, NHS Scotland and wider partners.

1. Ensure that health policy reflects the totality of sex and gender-related health inequalities.
2. Ensure that health research and data reflect the impact of sex and gender on health experiences and outcomes, including how sex and gender intersect with other protected characteristics.
3. Ensure that the wider health workforce is required to undertake tailored training on the specific impact of sex and gender on health outcomes and experiences, in line with efforts to embed Realistic Medicine.
4. Invest in dedicated systems, services and spaces that address common sex and gender-related barriers that contribute to 'missingness' in healthcare.
5. Invest in campaigns to raise public awareness of the impact of sex and gender on health experiences and outcomes.

> 'Perhaps the most important lesson from this research is the vital role of the third sector in understanding and responding to sex and gender-related health inequalities.'

CONCLUSION AND NEXT STEPS

Sex and gender shape health in a range of ways – physiological, systemic, social, and cultural. This results in the 'missingness' of key demographic groups in accessing health care, delayed or mis-diagnosis, inappropriate treatment, and the reinforcement of stigma. The six recommendations in the this report provide a high-level blueprint for addressing these issues: better evidence, improved workforce understanding, inclusive infrastructure, public awareness, policy mainstreaming, and third-sector partnership.

We are a movement for health creation working to reduce health inequalities to enable the people of Scotland to live well. We believe that health is more than the absence of illness, and together with our members and partners we champion this belief. We collaborate to provide the national voice for third sector health organisations in Scotland.

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