Cross-Party Group on Health Inequalities
Monday 26th January 2026, 10-11.30am

Minute

Present

MSPs

- Emma Harper MSP
- Brian Whittle MSP

Invited Guests

- Anna Glasier OBE, Women's Health Champion
- Felicity Sung, Scottish Government
- Helen McCabe, Scottish Parliament

Non-MSP Group Members

- Beth Allen, Age Scotland
- Gillian Burton, Ash Scotland
- Susan Hunter, Befriending Networks
- Maja Mitchell-Grigorjeva, Bipolar Scotland
- Fiona Collie, Carers Scotland
- Helen Forrest, Children's Health Scotland
- Jessica Wilson, CHSS
- Alana Harper, Deaflinks
- Sarah Rogers, Families Outside
- Salena Begley, Family Fund
- Helene van der Ploeg, Grassmarket Project
- Joyce Cattanach, Headway East Lothian
- Bushra Riaz, Kidney Research UK
- Rebecca Hoffman, LGBT Health and Wellbeing
- Donna Lawrie, MECOPP
- Tom Wightman, PASDA
- Una Macfadyen, Plus Forth Valley
- Karen Sweeney, Plus Forth Valley
- Joseph Woollcott, Prostate cancer UK
- Helen Reilly, Queens Nursing Institute Scotland
- Gemma Richardson, RCPCH
- Alex Morrison, RCSED
- Carlene McAvoy, ROSPA
- Fiona McIntyre, Royal College of Pharmaceuticals

- Sarah Murray, Royal Voluntary Service
- Sarah Curtis, RSE
- Sarah Boath, SCDC
- Christine Muir, Scottish Recovery
- Katharine Timpson, Strathclyde University
- Rob Gowans, The ALLIANCE
- Jen Grant, The Food Train
- Christine Carlin, Voluntary Health Scotland
- Roisin Hurst, Voluntary Health Scotland
- Sarah Latto, Voluntary Health Scotland
- Cecily May, Voluntary Health Scotland
- Tejesh Mistry, Voluntary Health Scotland
- Paula Fraser, VOX Scotland
- Ian McCall, Walking Scotland

Non-Group Members

- Emilie McSwiggan, Advanced Care Research Centre
- Fiona Smith, NHS Ayrshire and Arran
- Elspeth Boxall, NHS Scotland
- Sam Whitmore, Public Health Scotland
- Sara Bradley, Wales School of Social Prescribing Research

Agenda item 1

Welcome and Apologies

Emma Harper MSP welcomed attendees.

Apologies:

- Carol Mochan MSP
- Hilda Campbell, COPE Scotland

Agenda item 2

Approve Minutes

Emma invited comments on the minutes of the previous meeting and AGM held on 10th September and asked for members to approve and second minutes.

Approved by Rob Gowans and seconded by Paula Fraser

Agenda item 3

Approve New Members

The following organisations were approved as new members of the CPG:

- Bite Back
- Acorn Resource Centre
- Thrive East Lothian
- Headway East Lothian
- EARS Independent Advocacy Service
- Lanarkshire Deaf Hub

Agenda item 4

Gender and Health

Emma introduced the theme and welcomed the speakers.

Speaker 1: Sarah Latto, Voluntary Health Scotland

Sarah explained that she is sharing some of the initial findings of a research project currently being undertaken by VHS.

She shared that they landed on gender and health as a theme because it surfaced as a key theme of discussions with VHS members to inform the VHS Manifesto for Health Creation. She also explained that gender seemed like an important theme given the current narratives around sex and gender which can be polarising and confusing, and that the legal discourse does not always reflect the way that gender is understood or experienced in reality.

Sarah then clarified that this research will not attempt to cover every element of the relationship between gender and health. It will instead reflect evidence from VHS members which provides some additional context to what we know from national and academic sources.

Sarah shared some of the findings from a review of national and academic data:

- Gender can have both a direct and an indirect impact on health outcomes.
- Women live longer than men but spend more years in poor health.
- Health inequalities related to gender can be compounded by other characteristics.
- Health research and funding historically prioritises men, resulting in gender data gaps.
- Non-binary and trans people often disengage from health services and report that clinicians do not understand their needs.
- Men are more likely to die by suicide than women, and are more likely to drink to excess, abuse drugs, and smoke.
- Women's pain and physical symptoms are more likely to be dismissed as psychological.

Sarah then shared the key themes that have emerged through the VHS research so far:

- The impact of biological sex and genetics on health, e.g. conditions wholly determined by biological sex such as gynaecological conditions or prostate cancer, conditions that are more prevalent in one biological sex such as ME or dementia, and the impact of biological sex on other aspects of health e.g. the different ways that the body responds to alcohol or illegal drugs.
- The relationship between the legal context and the reality on the ground - biology is only one part of the story when it comes to inequalities related to gender, and the majority of VHS members who participated in the research collect gender data that goes beyond biological sex but lack confidence or clarity about what gender means.
- Gender-related gaps in health 'infrastructure' – this refers to the physical presence of services or infrastructure to support health or wellbeing, e.g. the lack of gynaecological/maternity services in rural communities, the need for trans health clinics, and the impact of our built environment on perceptions of safety for women undertaking physical activity outdoors.
- Existence of systemic bias in attitudes of the health workforce, from medical researchers to frontline clinicians e.g. the routine testing of new medicines on male mice only, the fact that men are often under-diagnosed with eating disorders, the minimising of pain for many women, and the reporting of trans people being refused care – this systemic bias was described by one respondent as 'institutional gaslighting'.
- Impact of wider societal norms around gender – this reflects the fact that men and women are often treated according to, or internalise, societal gender norms e.g. women are more likely to become carers, men are less likely to seek medical help particularly for mental health issues.
- Impact of intersectional barriers on gender-related inequalities – evidence of health rationing according to age, dismissal of symptoms of post-menopausal women, maternity experiences and outcomes of people of colour, bisexual women appear to have worse health outcomes than other members of the LGBT community.

Sarah concluded by sharing that the research should be published later in the Spring/early summer and invited attendees to join VHS or sign up to their newsletter for further updates.

Speaker 2: Anna Glasier OBE, Women's Health Champion

Anna explained that she was going to talk about phase two of the Women's Health Plan

Phase one of the Women's Health Plan was launched in 2021. The aim is a Scotland where health outcomes are equitable across the population so that all women and girls enjoy the best possible health throughout their lives. The priorities of phase one of the plan were menstrual health, menopause, abortion and contraception, and heart health.

As a result of Phase One we now have a women's health champion, a women's health lead in every NHS board in Scotland. We have a dedicated women's health information plan on NHS Inform. We have bespoke training packages on both menstrual health and menopause for primary care practitioners. We have an NHS

Scotland menopause and menstrual health workplace policy, a specialist menopause service in every mainland health board, a women's health lived experience programme, and we have a women's health research fund.

Phase two of the plan provides a refreshed set of actions building on what we've done in phase one and includes some new areas of interest. We've consulted many stakeholders and were particularly keen to hear the voices of women and girls that we don't normally hear from – engaged five different third sector organisations: Age Scotland, British Heart Foundation, CEMVO, the Simon Community and the Young Women's Movement, as well as the Health and Social Care Alliance lived experience group.

The Women's Health Plan doesn't stand in isolation, and there are lots of other areas of Scottish Government with whom we work extremely closely, like maternity services, cancer, mental health and wellbeing, and a lot of non-health organisations as well.

In phase two we're introducing 4 new priority programmes:

1. Gynaecology - recognising that the waiting times to see a gynaecologist or to have a surgical gynaecological procedure, are shockingly long. We're developing a national plan for gynaecology, not only trying to bring down the waiting times, but also to think about redesigning gynaecology services, recognising that gynaecology is no longer a purely surgical specialty and a lot of gynaecology could be done outside the hospital setting.
2. The elimination of cervical cancer – should be possible because we have a vaccine, we have a screening tool and we have treatment of early changes in the cervix which prevents cervical cancer occurring. But the uptake of vaccination is decreasing and the uptake of cervical screening is decreasing even more dramatically. Aim to increase uptake of HPV vaccination and of cervical screening.
3. Brain health - out of the some 90,000 people living with dementia in Scotland, two-thirds of them are women, and the vast majority of unpaid carers for people with dementia are also women. So working with the CMO's new brain health and dementia risk steering group, we're looking at the particular needs of women with regard to brain health.
4. Innovation in women and girls' health - look at the transformative impact of innovation which should have a pivotal role in providing the best quality care. This is not just technology, but different ways of doing things better than they have been done previously.

There are 40 new actions in phase two, many for the Scottish Government as health boards are struggling. There are four thematic areas:

- The first is the health of women and girls and covers cross-cutting actions.
    - We want to improve women's health research.
    - We want to improve data collection on women's health.
    - We want to continue to raise awareness and improve the health information available to the public, taking into account their intersectional needs.

- Optimising future health - most women live for 30 years after the menopause so we're focusing our actions on optimising women's health across the life course with a specific focus on bone health, pelvic floor health and heart health.
- Gynaecology and reproductive health - improving access to care and treatment for menopause, menstrual health and so on.
- Abortion, sexual health and contraception – continue to promote actions related to improving equity in abortion provision across Scotland and exploring the issues of hormone hesitancy among young women, where there's a tendency to abandon hormonal methods of contraception.

Panel Discussion: Chaired by Tejesh Mistry, Voluntary Health Scotland

Panellists:
- Rebecca Hoffman, LGBT Health and Wellbeing
- Joseph Woolcott, Prostate Cancer UK
- Fiona Collie, Carers Scotland

Tejesh invited all panellists to introduce themselves and share their rationale for participating in the VHS research.

Fiona: caring is impacted by gender and carers are more likely to be women and are more likely to be caring much earlier than men. Women's physical and mental health, but particularly their physical health, is significantly poorer than male carers. That's the driver for us to get involved and to find more of the solutions.

Joseph: Prostate cancer is a cancer that affects only men. Only men have a prostate. That comes with its own particular set of societal issues about health-seeking behaviours, including reluctance to go to the doctor. It is also intersectional - if you're a black man, you've got a one in four chance of prostate cancer. If you're white, you've got a one in eight.

Rebecca: Our interest in health inequality within the community stems from the fact that there are multiple health inequalities experienced by a variety of groups within the LGBT community. This includes experiences of minority stress, discrimination, ostracisation and stigma throughout the life course and the impact that that can have on physical health outcomes as well as mental health outcomes. Also, the impact of a lack of access to LGBT informed care.

The 2022 NHS Health Needs Assessment, a large survey of LGBT people living in Scotland, found significant health and well-being inequalities for bi women and for trans people in terms of mental health and wellbeing.

We have a trans and non-binary health clinic, a sexual health clinic, and part of what we offer there is cervical screenings and we're hoping to be able to expand that in future to more gendered health care or what is perceived to be gendered health care for the community.

Tejesh: What are those systemic issues that you're coming across and what are the consequences for your communities?

Fiona: Our research highlights the level of carers who are missing out on health appointments and we have found that for women that is more likely to be the case. Research around hospital discharge found that women were significantly less likely to be asked if they were willing or able to provide care, significantly less likely to feel no pressure to care, but also significantly less likely to receive the services they needed on discharge to protect their own health and wellbeing and the health and wellbeing of the person that they care for.

Rebecca: Trans and non-binary people, particularly, are facing significant barriers to access to health, whether that be access to LGBT informed mental health and wellbeing support or whether that is access to gender identity health care. Currently in Scotland, access to gender identity health care has around a seven-year wait and if you're waiting at the Sandyford, you will be waiting approximately 80 years.

We also found similar inequalities for bi women, and we are in the process right now of doing a scoping research project with bi women to try and understand why these inequalities exist and what needs to be done to alleviate those inequalities.

LGBT people seeking asylum or those with refugee status experience barriers to accessing health care - there's the intersection of experiences of misogyny and LGBT phobia or queer phobia for asylum seekers and refugees, as well as racism. Asylum seekers don't have the right to work, don't receive any benefits and only receive a small allowance or don't receive any allowance at all, quite often have difficulty registering for GPs, have difficulty travelling to doctor's appointments, have difficulty being believed as well.

Joseph: a lot of data is out of England because we can't get it from Scottish data. The National Prostate Cancer Audit looks at prostate cancer data across health systems in England and Wales. If you are black, you are 14% less likely to receive a NICE approved treatment than if you are white – strong correlation between health avoidance in areas of deprivation. At UCLH, there is a prostate cancer buddies programme where a black man diagnosed with prostate cancer is partnered with a black man who can talk to that person about their treatment options and actually interact with them in a way that that person is familiar with. This is an example of good practice.

There is also an urban/rural divide where men in urban areas have easier access to treatment.

Tejesh: where do you see the solutions to tackling these health inequalities from your perspective?

Fiona: A targeted plan for Carers which looks at intersectional barriers, and addresses carer poverty. To actually look at the scale of the problem and identify how we get carers the support that they need, get them identified early, get them the health checks that they need, including screening.

Joseph: In deprived areas, men diagnosed with prostate cancer are 39% more likely to have worse outcomes than people not living in deprived areas. There's probably all sorts of prostate specific interventions and pathways I should be talking about

here but I would suggest the one thing to do is raise the general levels of prosperity in areas where they're worst.

Rebecca: it needs a cross-governmental approach and a public health approach. That comes in terms of population health, but also in terms of really looking at the ways that we can challenge discrimination and, you know, lack of access to equitable health care.

Questions and Discussion

Emma thanked all speakers and panellists and invited questions.

Tejesh: We've got the Women's Health Champion here and I wondered from Anna's perspective what was the thinking behind that and do you think that's something we should replicate more across other areas to raise the profile or to drive that planning and action and implementation?

Anna: I thoroughly enjoy the job. It's taken me quite a while to learn how to do it because there isn't another champion, so there's nobody that you can learn from. I think I've learned that you have to make use of a number of different resources and and where relevant, try and go to the top people. I think there are also times when you have to be a little bit firm and say, why are we saying we can't do things when we should be saying, how can we do things differently.

Felicity Sung (Scottish Government): Having a champion for women's health has probably opened doors that we might not otherwise have been able to and enabled us to have conversations with people we may have struggled to speak to. Anna is also very much part of the team. Having a women's health champion has made a real difference and also having someone in each of the boards who has an interest and a passion for women's health.

Christine Muir: I'm particularly interested in hearing about the women's health leads. It's really great news that there's one in every NHS board and I'm just wondering about the level of involvement and are these paid roles?

Felicity: The women's health lead role is something that people in the boards are doing on top of their day-to-day jobs. We tend to have someone who sits at a more strategic level, for example, a director of public health or a director of nursing. But also they'll have someone working with them on a day-to-day level.

I suppose it's more outputs, what they're going to do, how do they think about what's in the women's health plan and how they apply that to the work they're doing, what their local priorities might be in terms of women's health I think as we move into phase two, we'll have another little look at that and think about how that's working. And as we move forward since the publication of the plan, the innovation that's happening across Scotland through the work of the Leads is really impressive and exciting.

Anna: we have quarterly meetings with them and we tend to go out and visit the boards from time to time. It gives the leads an opportunity to get senior staff along to hear a lot more about women's health.

Helen Forrest: What steps can be taken to ensure children's rights are embedded across all health inequality workstreams? How can children's organisations like Children's Health Scotland contribute more directly to shaping policy on early intervention and health literacy for children and young people?

Sarah: I think it's about engaging with organisations like VHS, contributing to organisations like us when we were calling for evidence around these types of things and feeding that in. I think it also reflects the fact that the health system that we currently have does organise primarily along the lines of health conditions. If we had more of an approach where we are looking at health more broadly according to things like gender or age or ethnicity, then that would make an enormous difference.

Agenda Item 5

Any other business

Emma invited Sarah to speak to an AOB item around the future of the CPG.

Sarah: this is the last meeting of the CPG on Health Inequalities before the election in May. If we wish for this CPG to continue, according to current rules we must identify cross-party membership of the CPG from the new MSP cohort, including a convenor or co-convenors, hold an initial meeting and re-register within 90 business days of the first meeting of parliament after the election.

However, the Scottish Parliament are currently reviewing arrangements regarding CPGs so this may change. There has been some suggestion that the Parliament may want to reduce the number of CPGs. Currently there are 123.

VHS, as the secretariat of this CPG, will endeavour to ensure that this CPG continues but there are no guarantees. VHS will keep members updated on developments.

Emma: I do know that there's been discussions that CPGs may not start for the first six months in the next session. I definitely think this is a really important cross-party group because I learned so much from just being here and chairing the meetings.

The minutes for this meeting will be shared on the CPG webpage on the Scottish Parliament webpage and will be circulated with the slides to all CPG members.

Tejesh thanked both Emma and Brian for their support of the CPG as co-convenors.

Emma thanked all attendees and closed the meeting.