Expert Report for the UK Covid-19 Public Inquiry

Module 2: Pre-existing inequalities experienced by LGBTQ+ groups

Author: Professor Laia Bécares

About the author

Laia Bécares (BA, MPH, PhD) is Professor of Social Science and Health, Department of Global Health and Social Medicine, Faculty of Social Science and Public Policy, King's College London. She has extensive experience in researching and publishing on the role of structural and societal determinants in leading to health inequities, including on the unequal impact of the COVID-19 pandemic on LGBTQ+ populations and on minority ethnic groups. Her research has attracted funding by The Nuffield Foundation, The Health Foundation, and the Economic and Social Research Council.

Author statement

I confirm that this is my own work and that the facts stated in the report are within my own knowledge.

I understand my duty to provide independent evidence and have complied with that duty.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Professor Laia Bécares

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Introduction

1. In this report I describe the inequalities in health and social outcomes experienced by lesbian, gay, bisexual, trans, queer, and more (LGBTQ+; LGBTQ+; the "plus" including those who do not identify with any such label) groups prior to the Covid-19 pandemic. The evidence described distinctively shows that LGBTQ+ inequalities are stark and long standing, with worse health, healthcare, and social outcomes for LGBTQ+ groups, compared to heterosexual and cisgender populations, documented over several decades. As detailed in Topic 3, LGBTQ+ inequalities are the result of heterosexism and/or cisgenderism.

2. There was considerable research published before January 2020, documenting increased rates of poor mental and physical health, and social vulnerability experienced by LGBTQ+ groups. Pre-existing health and social inequalities have the potential to lead to different outcomes for LGBTQ+ populations, and exacerbate existing vulnerabilities as a result of Covid-19 infection, and/or as a result of measures taken to respond to the pandemic.

3. It is important to note that a significant proportion of this evidence was commissioned and published by governmental bodies or by government-related organisations (including Public Health England, the Department of Health, the Government Equalities Office, the Equality Human Rights Commission, and the Scottish Government).

4. The evidence presented in this report is from the UK, unless noted (for example, when using findings from systematic reviews and/or meta-analyses that include international data). Due to persistent under-investment in research and data infrastructure for LGBTQ+ populations, there is a dearth of population-level studies on the health, social, and economic circumstances of LGBTQ+ groups. Limitations around data availability are graver in Northern Ireland and Wales, although large-scale data of a quantitative nature is also limited in Scotland and England.

5. Where possible, figures presented are from existing population-based studies (and therefore mainly from England). Where available I also present findings from research studies based on convenience samples, with the aim of presenting evidence for all devolved nations. Findings from these studies may not be generalised to all LGBTQ+ populations in their countries, or in the UK, but reflect the target population of interest, and provide valuable evidence to understand the health and social circumstances of LGBTQ+ people.

6. The devolved administrations have had different approaches and policies to equality issues than the UK Government. For example, same-sex marriage was legalised in England, Wales, and Scotland in 2014, but in Northern Ireland this did not take place until 2020; legislation that allowed same-sex couples to adopt a child came into effect in 2005 in England and Wales, 2009 in Scotland, and 2013 in Northern Ireland; there have been anti-discrimination laws in all areas on sexual orientation and gender identity in England and Wales, and Scotland since 2010, but there are only limited protections for gender identity in Northern Ireland. Differences in policies are likely to manifest themselves in greater structural inequality experienced in Northern Ireland, but processes of heterosexism and cisgenderism, and their impacts on health and social outcomes, operate across nations so inequalities experienced by LGBTQ+ people, compared to heterosexual and cisgender people are prevalent and significant across the UK.

7. The LGBTQ+ umbrella term includes broad categories of sexual orientation and gender identity, which are highly heterogeneous between and within the broader groups. In addition, LGBTQ+ people embody other intersectional social identities that also experience discrimination (for example, with relation to ethnicity, age, disability), and this leads to differential outcomes. Where possible given data availability, I have provided evidence of inequality broken down by individual groups.

Topic 1. Pre-existing health inequalities for LGBTQ+ groups, January 2020

8. This section presents evidence of existing health inequalities experienced by LGBTQ+ groups before January 2020. The focus is on the health-related outcomes that had a strong potential to lead to worse outcomes during and after the pandemic, either in terms of poorer prognosis from Covid-19 infection, or in relation to wider impacts on mental health and health service use as a consequence of measures implemented to control the pandemic.

9. Many of these pre-existing health inequities were longstanding, and had been documented across several outlets, including in reports commissioned and published by public bodies associated with the Government. Health inequities which had a strong potential to lead to worse prognosis from Covid-19 infection for LGBTQ+ people are outlined below.

10. In addition, pre-existing inequalities in mental health meant that measures taken to respond to the pandemic, such as lockdown and social distancing, had a strong potential to magnify vulnerabilities for LGBTQ+ people. Prior to January 2020, there was well-documented evidence that LGBTQ+ people had higher rates of depression, anxiety, suicidal ideation, and self-harm compared to heterosexual and cisgender populations. There was also robust evidence documenting increased likelihood of experiencing crime and violence, including within the home by residents of the same household who were not supportive, or hostile, of their sexual orientation and/or gender identity. They also had high rates of isolation, and the nature of their social networks, which are less likely to rely on kin relationships, meant that they were at increased risk of further social isolation and worsening mental health following social distancing and lockdown measures.

Physical Health

Being overweight

11. Prior to the pandemic, there was clear evidence from the UK of unhealthy weight among lesbian and bisexual women. The likelihood of being overweight was 41% higher for lesbian women, and 24% higher for bisexual women, than for heterosexual women (Semlyen et al., 2019) of the same health and sociodemographic characteristics.

Respiratory conditions

12. Lesbian and bisexual women have higher rates of asthma than heterosexual women. The chances of having asthma are 44% higher for lesbian women, and 64% higher for bisexual women, compared to heterosexual women of the same age (Meads et al., 2018).

Cardiovascular disease (CVD)

13. Reviews of the international literature have identified an elevated risk of CVD risk factors (including hypertension and high cholesterol) among lesbian women and gay men, compared to heterosexual people (Caceres et al., 2017). A review of US-based studies reported that among trans men and women receiving cross-sex hormone therapy, there is an increased risk of worsening CVD risk factors (such as blood pressure elevation, insulin resistance, and lipid derangements), and for trans women, and increased risk of thromboembolic events (for

example blood clots in the veins, which was found to be at increased risk in patients with Covid-19) (Streed et al., 2017).

Cancer

14. LGBTQ+ people are overrepresented among patients with certain types of cancer. Gay men were 45% more likely to report cancer in the past five years than heterosexual men, and gay or bisexual men are over-represented among men with Kaposi's sarcoma, anal, and penile cancer (Saunders et al., 2017). One in 12 lesbian and bisexual women aged between 50 and 79 has been diagnosed with breast cancer, compared to one in 20 of all women of the same age (Hunt and Fish, 2008). Bisexual women have almost twice the rate of cervical cancer than heterosexual women (Robinson et al., 2017). Lesbian and bisexual women are overrepresented among women with oropharyngeal cancer, and among patients with mesothelioma, stomach, and endometrial cancer (Saunders et al., 2017).

15. 15% of lesbian and bisexual women over the age of 25 have never had a cervical smear test, a test to help prevent cancer, compared to 7% of women in general (Hunt and Fish, 2008). Bisexual people are less likely to have received a diagnostic test for cancer in the previous 12 months (Hulbert-Williams et al., 2017). Gay and bisexual men have very low rates of checking their testicles monthly as a recommended preventative measure against testicular cancer (one third of gay or bisexual men) or discussing prostate cancer with a healthcare professional (one in ten of gay or bisexual men) (Guasp, 2012). Disruptions to cancer screening services were experienced during and after the Covid-19 pandemic, and it is likely that this has further exacerbated pre-existing inequalities in cervical screening.

General self-rated health

16. LGBTQ+ people report worse general health than heterosexual and cisgender people of the same age, ethnicity, and area-level deprivation (Elliott et al., 2015).

    16.1. Studies conducted by Stonewall in England, Scotland, and Wales, show that one in four gay and bisexual men report being in fair or bad health, compared to one in six men in general (Guasp, 2012).

    16.2. In England, 21% of heterosexual women report "fair" or "poor" general health, compared with 25% of lesbian women, 32% of bisexual women, and 27% of women who identify with another sexual orientation (Elliott et al., 2015).

    16.3. In Scotland, age-standardised figures show that 67% of lesbian, gay, bisexual people report "good" or "very good" health, compared to 75% or heterosexual people (Hunter, 2017).

    16.4. Among people aged 50 and older, findings from a meta-analysis of 24 surveys found that lesbian, gay, or bisexual men and women have 1.2 times the odds of poor self-rated health compared to heterosexual people of similar sociodemographic characteristics (Beach, 2019).

Limiting long-term illness

17. Lesbian, gay, and bisexual people have a higher likelihood of reporting limiting longstanding illnesses than heterosexual people. Gay and lesbian people are 63% more likely and

bisexual people are twice as likely than heterosexual people of the same sociodemographic characteristics to report limiting longstanding illness (Booker et al., 2017). Men who have sex with men are 50% more likely than men who report sex exclusively with women to have a long-standing illness, disability, or infirmity (Mercer et al., 2016).

Having a disability

18. Findings from the Government Equalities Office's National LGBT Survey, the largest national survey of LGBT people conducted in the UK (with over 108,000 participants in England and Wales), show that among LGBTQ+ people, 33% of trans respondents, compared to 14% of cisgender respondents, consider themselves to have a disability (GEO, 2018). In Scotland, a study by the Scottish Transgender Alliance found that 37% of survey respondents reported having a disability (Morton, 2008).

Mental Health

19. Prior to January 2020, there was well-documented evidence that LGBTQ+ people had higher rates of depression, anxiety, suicidal ideation, and self-harm compared to heterosexual and cisgender populations. Pre-existing inequalities in mental health meant that measures taken to respond to the pandemic, such as lockdown and social distancing, had a strong potential to magnify vulnerabilities for LGBTQ+ people.

Common mental disorders

20. LGBTQ+ people are at higher risk of common mental disorders (including anxiety and depression).

20.1. Adult lesbian, gay and bisexual people are at least 1.5 times more likely to be at risk for depression and anxiety disorders compared to heterosexual people (King et al., 2008). Data from England, Scotland, and Wales show that 13% of gay and bisexual men are currently experiencing moderate to severe levels of mixed depression and anxiety. This compares to 7% of men in the general population (Guasp, 2012).

20.2. LGBQ+ people in England report two to three times the rate of longstanding psychological or emotional conditions of heterosexual men and women of the same sociodemographic characteristics (Elliott et al., 2015).

20.3. Sexual minority adolescents are more likely to report depressed mood compared to heterosexual adolescents with the same family environment and socioeconomic status (Pesola et al., 2014). Among people either under 35 years of age or over 55 years of age, lesbian/gay identity is associated with a two-fold increase in the risk of common mental disorder symptoms when compared to heterosexuals with the same sociodemographic characteristics. Bisexual identity is associated with more than twice the risk of poor mental health compared to heterosexual people with the same socioeconomic characteristics (Semlyen et al., 2016).

20.4. A study of trans people in Scotland found that 88% of trans people have experienced depression, 80% have experienced stress and 75% have experienced anxiety (McNeil et al., 2012).

Suicide and self-harm

21. Sexual minority people are more than twice as likely as heterosexual people to report suicide attempts, and almost three times as likely as heterosexual people to self-harm (Chakraborty et al., 2011). A meta-analysis of international studies found a two-fold excess risk in suicide attempts among lesbian, gay and bisexual people (King et al., 2008), compared to heterosexual people. Gay and bisexual men are at a particular high risk of suicide attempt (four times higher), compared to heterosexual men (King et al., 2008).

21.1. A study on trans people aged 50 and older accessing gender identity clinics found that among older trans women, 17% reported non-suicidal self-injuries; around three times higher than average among the general population (Bouman et al., 2016).

21.2. Sexual minority youth report almost a three-fold increased rate of suicidality as compared with heterosexual youth. Sexual and gender minority youth are more likely than heterosexual youth to report ideation, intent/plans of suicide, suicide attempts, and suicide attempts requiring medical attention (Marshal et al., 2011). 84% of trans young people have deliberately harmed themselves at some point. This compares to 10% of young people in the general population (Bradlow et al., 2017). The proportion with intent is higher among minoritised ethnic gay/lesbian or bisexual young people than their white counterparts (Guasp and Taylor, 2012).

21.3. In Scotland 50% of LGBTQ+ young people and 63% of transgender young people experience suicidal thoughts or behaviours (Lough Dennell et al., 2017). 53% of trans people have self-harmed at some point in their lives, with 11% currently self-harming (McNeil et al., 2012). In Wales, 77% of trans young people and 61% of cisgender lesbian, gay, and bisexual young people have deliberately harmed themselves at some point (Bradlow et al., 2017b).

21.4. For LGBTQ+ youth, experiencing bullying is a strong predictor of self-harm and attempted suicide (see Topic 3 for further details on discrimination in educational settings). For example, a study in Northern Ireland found that among young same-sex attracted men that reported experiencing bullying at school, 84.5% thought about suicide, 35% had attempted suicide and 41% had self-harmed (McNamee, 2006). In Scotland, 73% of LGBTQ+ young people and 83% of transgender young people who had experienced mental health problems had been bullied at school (Lough Dennell et al., 2017).

Loneliness, social isolation, and social support

22. LGBTQ+ people experience greater rates of social isolation than heterosexual people, particularly in later life. Lockdown measures may have had particularly detrimental effects for LGBTQ+ people given their pre-existing levels social isolation, the nature of their social networks, which are less likely to be kin-based, and the closing of LGBTQ+ safe spaces and community organisations that provide support to the community and a place to connect with other LGBTQ+ people.

23. Two reviews commissioned and published by the Equality and Human Rights Commission found that LGBTQ+ people often experience isolation from their families of origin following

rejection because of their sexual orientation or gender identity or expression (Mitchell and Howarth, 2009, Mitchell et al., 2009).

24. LGBT+ young people are more likely than their heterosexual and/or cisgender peers to report feeling lonely on a daily basis (52% of LGBTQ+ people compared to 27% of young people who are not LGBTQ+). There are some differences across devolved nations in reports of loneliness; 60% of young LGBTQ+ people in Wales, 59% in Northern Ireland, 56% in Scotland report that they feel lonely on a daily basis (Just Like Us, 2021).

25. LGB older people (aged 50 and older) are less likely to have seen a friend the previous day (64% for LGB people compared to vs 72% for heterosexual people), possibly suggesting that social networks of older LGB people are not as immediately accessible as those of non-LGB people (Kneale, 2016). LGB people aged 50 and older are more likely to report feeling lonely often, and are more likely to be excluded from social relationships. They are also less likely to have children and grandchildren, which has implications for levels of social support and informal care (Kneale and French, 2018).

26. There is some evidence that social networks and support for LGBTQ+ people may not include people they share the same household with, and may be more geographically dispersed. For example, families of choice take a particularly crucial role in the face of providing care in later life (Willis et al., 2011). LGB older people are more likely to provide care for a close friend or relative than heterosexual older people, and this happens earlier than for non-LGB people. LGB people start to provide care for a relative or close friend 21 years earlier than heterosexual people (at 54 years for LGB people, and at 75 years for heterosexual people) (Kneale and French, 2018). Given these differences in the sources of social support for LGBTQ+ populations, and the characteristics of their networks, measures like lockdown and restrictions to domestic travel are likely to have had a disproportionate impact on LGBTQ+ groups.

Grief

27. The increased rates of mortality during the Covid-19 pandemic have seen a rise in complex grief disorder, due to many bereaved carers being unable to say goodbye, take part in grieving rituals, or experiencing guilt around the circumstances of the death of their loved one (APPG, 2023). For LGBTQ+ people, experiences of complex grief disorder compound experiences of disenfranchised grief, which result from a loss of a loved one from a relationship that cannot be openly acknowledged, accepted, and mourned. LGBTQ+ people may feel under pressure to hide their grief, and not be identified as needing support, further exacerbating poor mental health.

Sexual and Reproductive Health

HIV

28. International data from almost 350,000 patients in 38 countries show that people living with HIV are at increased risk for development of severe illness and death due to Covid-19 (Bertagnolio et al., 2022). The last Public Health England report published before January 2020 (PHE, 2019) shows clear inequities in prevalence of HIV for LGBTQ+ populations, particularly for gay and bisexual men; of the estimated 103,800 people who were living with diagnosed and undiagnosed HIV at the end of 2018, 18.4% were heterosexual men, and

48% were gay and bisexual men (PHE, 2019). HIV prevalence is higher among Black and other white gay and bisexual men, compared with gay and bisexual men (Hickson et al., 2017), and among trans women, compared with all adults of reproductive age (Baral et al., 2013).

29. Although new transmissions between men who have sex with men have been steadily falling, ethnic minority MSM are over-represented in new transmissions; data from Public Health England show that 84% of cases of newly diagnosed HIV are men who have sex with men (MSM) of white ethnicity and 14.6% of newly diagnosed HIV cases are ethnic minority MSM (Jaspal et al., 2016).

30. Data from Public Health England show that trans adults with HIV are twice as likely as other adults to be diagnosed late with a CD4 count of <350 mm3 (Jaspal et al., 2018). Late diagnosis is associated with poorer outcomes, including increased risk of severe disease and death.

Sexually transmitted infections (STIs)

31. As with other healthcare services, the Covid-19 pandemic disrupted the delivery of sexual health services in the UK. This may have exacerbated pre-existing inequalities in STIs for the LGBTQ+ population. Although there is limited information about STIs among sexual minority women, evidence shows that men who have sex with men (MSM) are disproportionately affected by both syphilis and gonorrhoea. Similarly, women who report sex with women and men are more likely to report diagnoses of chlamydia, pelvic inflammatory disease, or genital warts, compared with women who report sex with men only (Mercer et al., 2007).

Smoking and alcohol use

Smoking

32. Smoking was found early in the pandemic to be a risk factor for more severe outcomes following Covid-19 infection, including death (Clift et al., 2022). Several studies show increased rates of smoking among LGBTQ+ people. Gay and bisexual people are up to 40% more likely to smoke than heterosexual people (ONS, 2018), and levels of smoking are higher for trans people (McNeil et al., 2012). Young gay and bisexual people (aged 18 to 19) are almost twice as likely to smoke as heterosexual young people of the same age (Hagger-Johnson et al., 2013).

Alcohol use

33. LGBTQ+ people have been found to be more likely to use alcohol and other drugs, and there was strong potential for this inequality to have been exacerbated during the Covid-19 pandemic, when alcohol and other drug use increased compared to previous years (Burton et al., 2021, Schmidt et al., 2021). In the last 'LGBT in Britain' report prior to the Covid-19 pandemic, Stonewall found that 16% of LGBTQ+ people reported drinking almost every day in the last year. This compares to 10% of adults in the general population (Bachmann and Gooch, 2018a). The LGBT in Scotland Health Report found that 14% of LGBTQ+ people drank alcohol almost every day over the last year. This compares to 9% of adults in the general population (Bridger et al., 2018). In Northern Ireland, studies show that 91% of

LGBTQ+ people drink alcohol, compared to 74% of the Northern Ireland population (Rooney, 2012).

34. Lesbian and bisexual women are at a particularly high risk of substance dependence, including at 4 times the risk of heterosexual women to report alcohol use in the last 12 months; over 3 times the risk to report drug dependence; and over 3 times the risk to report a substance use disorder, compared to heterosexual women (King et al., 2008).

35. Among people aged 55 and over, LGB people are more likely to drink alcohol at least five days per week, compared to heterosexual people of the same age. Compared to 20% of heterosexual men aged 55 and older, 35% of gay and bisexual men of the same age drank alcohol at least five days per week. Compared to 15% of heterosexual women aged 55 and older, 19% of lesbian and bisexual women of the same age reported drinking at least five days per week (Guasp, 2011).

36. Among young people, a study using data from the Longitudinal Study of Young People in England (LSYPE) found a two-fold increased likelihood of drinking more than two days a week for 18–19-year-old lesbian and gay young people, compared to heterosexual young people of the same age (Hagger-Johnson et al., 2013).

Topic 2. Pre-existing social and economic inequalities for LGBTQ+ groups, January 2020

37. In this section I provide evidence of existing underlying social and economic inequalities that had been documented by January 2020. Factors considered here are relevant to the Covid-19 pandemic because they were known to put people at increased risk of infection and severe outcomes from Covid-19 (for example, experiencing socioeconomic disadvantage), or because they increased vulnerability and further contributed to widening inequalities for LGTBQ+ people (for example, experiencing violence within the home, experiencing online harassment, or feeling excluded from health and social care).

Education

38. The Equality and Human Rights Commission (EHRC) found that LGB pupils are disadvantaged in comparison to heterosexual pupils because they do not receive sex and relationship education pertinent to their needs. The EHRC review, which synthesised evidence from England, Scotland, Wales, and Northern Ireland, concluded that heterosexism in schools alienates and marginalises LGB pupils (Mitchell et al., 2009) and can be linked to academic under-achievement among boys, and restricted activities and sporting under-achievement among girls. The EHRC report also established a link between homophobic bullying, absenteeism from school and poor educational attainment (Mitchell et al., 2009). More information on bullying and harassment in schools is provided in Topic 3.

Income, material deprivation, and receipt of benefits

39. LGB people are more likely than heterosexual people to experience material disadvantage, with bisexual men and women, and trans people being particularly disadvantaged (Noah Uhrig, 2015; Morton, 2008). Although 55% of trans people have a degree or postgraduate degree, only 30% have a gross annual income of over £20,000 and 48% have a gross annual income of under £10,000 (Morton, 2008).

40. Gay and bisexual men are significantly more likely to be in receipt of certain state benefits; gay men are significantly more likely to be in receipt of income support, housing benefit and council tax benefit as compared to heterosexual men. Bisexual men are significantly more likely to be in receipt of income support (Noah Uhrig, 2015).

41. LGB people are more likely than heterosexual people to reach older age having experienced severe financial hardship (17.4% among non-LGB compared to 24.6% among LGB people) (Kneale and French, 2018).

Area deprivation

42. Sexual minority people are more likely to live in deprived areas: 19% of heterosexual men live in areas in the most deprived quintile, compared with 29% of gay men, 31% of bisexual men, and 37% of men who self-identify with another sexual orientation. 18% of heterosexual women live in the most deprived quintile of deprivation, compared to 26% of lesbian women, 28% of bisexual women, and 35% of women who self-identify with another sexual orientation (Elliott et al., 2015).

Participation in the labour market

43. The Government Equalities Office reported in 2011 that difficulty in gaining and retaining employment was considered the most important challenge that trans people face, with 66% of respondents identifying it as the most important challenge (GEO, 2011). A study in Scotland reported high levels of unemployment (37%) and self-employment (20%) among trans people (Morton, 2008). There is also evidence of a 'gay glass ceiling' such that gay and bisexual men working in British universities are less likely to hold senior ranks than heterosexual men of the same age, experience, and geographical region (Frank, 2006).

Exposure to violence/harm

44. LGBTQ+ people are at greater risk than the general population of being victims of crime (GEO, 2018). Findings from the British Crime Survey show that LGB people's likelihood of victimisation from any crime is at least 1.3 times greater than that of heterosexuals. Bisexual people in particular have a greater likelihood of victimisation, compared to both lesbian and gay people, as well as heterosexual respondents (Mahoney et al., 2014). Around 40% of LGB people say they are worried about being the victim of a crime. This compares to 13% of the general population (Dick, 2008).

45. Hate crimes related to sexual orientation are the second most common type of hate crime reported in England, Wales, and Scotland (Home Office, 2018, Roberts, 2018). Figures related to hate crime under-estimate the extent of hate crimes towards the LGBTQ+ community due to under-reporting. Findings from community surveys show that 60% to 80% of LGBTQ+ victims/survivors have never reported incidents to the police or attempted to find advice or protection from services (Hunt and Fish, 2008).

46. Minoritised ethnic lesbian, gay and bisexual people are more than twice as likely as white lesbian, gay and bisexual people to report feeling homophobic attacks are a problem in their local area (Guasp and Taylor, 2012). They are also twice as likely as the general LGB population to experience a physical assault (Dick, 2008).

47. 10% of lesbian, gay and bisexual people with a disability consider homophobic attacks as a problem in their neighbourhood, compared with 5% of LGB people who don't have a disability (Guasp and Taylor, 2012).

Violence within the home

48. Rates of violence within the home are concerningly high for LGBTQ+ people, with 44% of lesbian and bisexual women and 41% of gay and bisexual having experienced domestic abuse for more than one year (Hunt and Fish, 2008; Guasp, 2012). Violence within the home increased during the pandemic; for LGBTQ+ people this presented a serious issue, given pre-existing high rates of domestic violence, and the situation created by lockdown whereby some LGBTQ+ people may have been isolated in households that were hostile of their sexual orientation and gender identity. A research report into trans people's experience of domestic abuse in Scotland found that 80% of trans people have experienced emotional, physical or sexual abuse from a current or former partner (Roch et al., 2010).

Access to public services

49. LGBTQ+ people have historically experienced exclusion from health and social care settings via a lack of provision of appropriate services, limited knowledge and understanding by providers of the specific health needs of LGBTQ+ people, difficulty in accessing services, and discrimination within services. Although limited access and poor satisfaction with health and social care is common across LGBTQ+ groups, this section describes areas of pre-existing inequality that had a strong potential to lead to different outcomes and exacerbate vulnerabilities for LGBTQ+ people during and after the Covid-19 pandemic.

Gender identity clinics

50. Trans and gender diverse people already experienced long waiting lists to access clinics, hormones and surgery before the pandemic; changes to services and further delays in access to health and social care may have exacerbated these inequalities. Findings from The National LGBT Survey (GEO, 2018) show that 50% of trans men and 43% of trans women respondents had accessed gender identity services in the past year. Among trans respondents who had accessed or tried to access gender identity services, 80% said that access had not been easy, and 68% said that the waiting lists had been too long. 33% of trans people said the services were not close enough to them.

51. This is much higher in the North West (51%) and Wales (54%) where at the time of the report (2018) there were no gender identity services (GEO, 2018). Findings from The Scottish Transgender Alliance's 2012 study show that among people who had attended Gender Identity Clinics in Scotland, 60% were seen within a year, 32% waited 1-3 years, and less than 10% waited over three years for an appointment. 58% of the participants felt that this wait had led to their mental health or emotional wellbeing worsening during this time (McNeil et al., 2012).

Residential care

52. LGBTQ+ people are more concerned than heterosexual people about the prospect of residential care. Consequently, LGBTQ+ people often delay their access to social care (Hudson-Sharp and Metcalf, 2016). The possibility of needing to live in a residential care home, loss of independence, and the need for care by others are major concerns for LGBTQ+ older people (Guasp, 2011). These concerns relate to their sexual orientation and gender identity or expression, and include the inability to be oneself, privacy, safety, cultural appropriateness of support, discrimination, and becoming disconnected from their communities and friendship networks (Hudson-Sharp and Metcalf, 2016). The result of these concerns risks escalating the individual's care needs so that they are more complex or severe when they do finally access care (Williams et al., 2016). These concerns and experiences are particularly relevant in the context of the Covid-19 pandemic, when residents in care homes were physically isolated from wider social networks. Many older LGBTQ+ people hide their sexual orientation and gender identity for fear of discrimination, and sustaining these efforts under lockdown, compounded with lack of access to support networks, may have worsened their mental and physical health.

53. Stonewall found that among lesbian, gay and bisexual people aged 55 and older, 70% of participants feel they would be able to be themselves if living in a care home (compared to 61% of heterosexual people of the same age). 65% feel they would have to hide things about

themselves from others (compared to 52% of heterosexual people of the same age) (Guasp, 2011).

54. Qualitative evidence from Wales shows that care environments are hetero-sexualised spaces where discussions and expressions of non-heterosexual identities and sexuality are absent, rendering lesbian, gay, and bisexual identities invisible (Willis et al., 2016). A study in Northern Ireland found that the provision of care in residential areas is based on a heterosexist assumption that all residents are heterosexual (Rainbow Project, 2011).

55. Potential discrimination from providers and other service users make LGBTQ+ older people concerned about being reliant on social care. As with health and mental health care services, LGBTQ+ people are concerned about being open to care providers about their sexual orientation or gender identity, particularly in a residential care setting (Hudson-Sharp and Metcalf, 2016). 76% of lesbian, gay and bisexual older people are not confident they would be treated with dignity and respect in a care home setting (compared to 71% of heterosexual of the same age) (Guasp, 2011).

Healthcare services

56. LGBTQ+ people are less likely to access key health services compared with heterosexual and/or cisgender people. They have historically been excluded from mainstream services, and report poorer satisfaction and lower quality of care. The pandemic has put the NHS under considerable pressure, and has driven increased demand for health care, growing waiting lists and a substantial elective care backlog. Due to pre-existing inequities in health and social care access and satisfaction, these increased pressures and reduced services are likely to have exacerbated inequities for LGBTQ+ populations.

57. An analysis of the English General Practice Patient Survey found that lesbians and bisexual women are around 20% less likely than heterosexual women to have visited the GP in the previous 3 months (Urwin and Whittaker, 2016). Data from Scotland show that only 76% of LGBTQ+ people have accessed their GP surgery in the last year, compared to 90% of the general population (Bridger et al., 2018).

58. LGBTQ+ are instead more likely to access emergency services. 18% of LGBTQ+ people have accessed accident and emergency services or casualty in the last year, compared with 12% of the general population. LGBTQ+ people are also more likely to use NHS 24’s phone service; 34% of LGBTQ+ people have accessed NHS 24's phone service in the past 12 months compared to 16% of the general population (Bridger et al., 2018).

59. The National LGBT Survey found that 80% of respondents had accessed or tried to access public healthcare services in the year prior to the survey. Overall, trans respondents (84%) are more likely than cisgender respondents (79%) to have accessed or tried to access public healthcare services. Amongst trans respondents, trans men (89%) and trans women (87%) are more likely than non-binary respondents (79%) to have accessed or tried to access services (GEO, 2018).

60. LGBQ+ patients report negative experiences with healthcare (including no trust and confidence in doctors, poor communication with doctors and nurses, and low satisfaction) more often than heterosexual people of the same sociodemographic characteristics (Elliott et al., 2015).

61. Negative experiences are particularly prevalent among trans people who try to access services (GEO, 2018). 41% of trans people in England, Scotland, and Wales said that healthcare staff lacked understanding of specific trans health needs. This number increases to 51% among trans people living in Wales (Bachmann & Gooch, 2018c).

Mental health services

62. Findings from the National LGBT Survey (GEO, 2018) show a substantial proportion of LGBTQ+ people had tried to access mental health services in the 12 months prior to the survey but had not been successful. Among people aged 55 and older, 43% of lesbian, gay, and bisexual people are not confident that mental health services would understand and meet their needs. This compares with 33% of heterosexual people of the same age (Guasp, 2011). 29% of trans people felt their gender identity was not validated as genuine by mental health services providers, instead being treated as a symptom of mental ill-health (Ellis et al., 2015).

Housing

63. Housing is a particular concern for LGBTQ+ people, and particularly for trans people, because of the extensive aggression experienced by many LGBTQ+ people from neighbours and others in the area, and the break-up of many families on discovering a member of the family is trans (Whittle et al., 2007). The EHRC Sexual Orientation Research Review found that housing services often adopt a heteronormative attitude and overlook issues regarding sexual orientation and/or gender identity when assessing the need for and allocation of suitable housing. This includes not considering potential issues associated with sexual orientation and/or gender identity when issuing or re-issuing of a home, and failing to address potential problems LGBTQ+ people may face when in temporary and/or shared accommodation, such as a lack of privacy and potential homophobia, biphobia, or transphobia from housemates or other shelter residents (Mitchell et al., 2009).

Homelessness

64. LGBTQ+ people, and in particular youth and trans people, are at a particularly high risk of experiencing homelessness compared with heterosexual and cisgender populations. 24% of homeless young people (aged 16 to 25) are LGBTQ+. 77% of homeless young LGBTQ+ people stated that being LGBTQ+ was a causal factor in rejection from home (AKT, 2017). Only 2.6% of the housing services surveyed by the Albert Kennedy Trust recognised the unique needs of homeless LGBTQ+ young people and had targeted services. LGBTQ+ homeless people are less likely to seek help or support than non-LGBTQ+ peers, and feel less confident to approach services out of fear of discrimination (AKT, 2017).

Topic 3. Structural discrimination

65. In this section I describe heterosexism and cisgenderism, and resulting discrimination, experienced in the settings that structure people's lives, including education, employment, healthcare, and housing, among others.

66. LGBTQ+ inequalities in health, social, and economic outcomes are the result of structural heterosexism and/or cisgenderism.

66.1. Heterosexism is a system that structures societal institutions, policies, practices, norms and values based on the assumption that everyone identifies as heterosexual. Heterosexism denies, denigrates, and stigmatises any form of identity, behaviour, relationship, or community that is not heterosexual (Herek, 1990).

66.2. Cisgenderism is a system that oppresses, denigrates and pathologises self-identified gender identities that do not align with assigned gender at birth as well as resulting behaviour, expression, and community (Ansara and Hegarty, 2012).

67. Heterosexism and cisgenderism are systemic and structural, perpetuated by societal structures, and by institutions. They also lead to interpersonal discrimination – discriminatory behaviours by individuals, either in purpose or by omission – and to internalised negative beliefs by LGBTQ+ individuals about their sexual orientation and/or gender identity.

68. LGBTQ+ people experience heterosexism and cisgenderism over the course of their lives, and across different sectors and institutions. In 2018, the Government Equalities Office acknowledged the societal discrimination experienced by LGBTQ+, describing many of the domains in which it takes place (GEO, 2018), which are summarised here.

69. Other processes of oppression and domination like racism, classism, and ageism, among others, that operate at the micro and macro level, intersect with heterosexism and/or cisgenderism in the production of inequities for people who embody multiple marginalised identities (Bowleg, 2012).

70. The standard pandemic approach undertaken by core political and administrative decision-makers overlooked existing social and health vulnerability experienced by LGBTQ+ people and the increased risks they faced due to pre-existing health and social inequalities. An equitable, anti-heterosexist and anti-cisgenderist approach to the Covid-19 pandemic would be one where interventions explicitly consider sexual orientation and gender identity, with an understanding that disregarding them could lead to poor health and social outcomes for LGBTQ+ populations, and further exacerbate existing inequalities.

Experiences of interpersonal discrimination, including fear of harassment

71. The UK National LGBT Survey found that over two-thirds of all sexual minority respondents in England and Wales avoid being open about their sexual orientation for fear of a negative reaction (GEO, 2018). Around a quarter (26%) of LGBTQ+ people have experienced verbal harassment, insults or other hurtful comments and 40% have experienced an incident in the past year because of their sexual orientation. More than nine in ten of the most serious incidents went unreported, often because respondents thought 'it happens all the time' (GEO, 2018). In Northern Ireland, a report by the Rainbow Fund found that 21% of gay and bisexual

men and 18% of LGB women have been the victim of one or more homophobic hate crimes or incidents in the last three years (O'Doherty, 2009).

72. These experiences are common across the life course of LGBTQ+ people. Among younger LGBTQ+ people, almost a quarter (23%) have experienced physical assault and a substantial minority also report sexual abuse (Baker et al., 2016). LGB people aged 50+ are more likely to have experienced sexual assault than heterosexual older people (Kneale and French, 2018).

73. Discrimination attributed to other personal characteristics also occurs within the LGBTQ+ spaces. 51% of ethnic minority LGBTQ+ people face discrimination based on their ethnicity from within LGBTQ+ communities. This figure rises to 61% among black LGBT people. 26% of disabled LGBTQ+ people face prejudice in the LGBTQ+ community because of being disabled (Bachmann and Gooch, 2018a).

Discrimination in educational settings

74. LGBTQ+ students in the UK experience significant discrimination, bullying and harassment in educational settings, including online, with nearly half (45%) of lesbian, gay, bisexual and trans students are bullied at school for being LGBTQ+. This figure is much higher for trans students – 64% (Bradlow et al., 2017), of whom 9% were subjected to death threats. Furthermore, young trans women experience harassment or bullying at school, not just from their fellow pupils but also from school staff including teachers (Whittle et al., 2007).

75. In Northern Ireland, 70% of same-sex attracted 16-year-old boys experience bullying at school compared to only 28% of their opposite attracted peers. 62% of same-sex attracted girls are bullied, compared to 37% of their peers (Schubotz and O'Hara, 2011). In Scotland, findings from the largest research study on young LGBTQ+ people found that 71% of LGBTQ+ young people, and 82% of trans young people experience bullying in school on the grounds of being LGBTQ+ (Lough Dennell et al., 2017). In Wales, 54% LGBTQ+ students, and 73% of trans students experience bullying at school (Bradlow et al., 2017). These figures are likely to be an underestimate, since almost half of LGBTQ+ pupils (45%) who are bullied for being LGBTQ+ in school never tell anyone about the bullying (Bradlow et al., 2017).

76. Higher education provides a space for LGBTQ+ students to be themselves, and establish new networks. LGBTQ+ students continue to experience discrimination, but to a lesser extent than in school settings. Findings from a survey of over 4200 LGBTQ+ staff and students in higher education institutions (HEIs) in England, Wales and Northern Ireland found that LGB students report significant levels of negative treatment on the grounds of their sexual orientation; 13% felt they had been bullied or discriminated against since starting university (Valentine et al., 2009). A higher proportion of students report homophobia in Wales and Northern Ireland, in rural HEIs, and in post-1992 universities.

Discrimination in employment settings

77. LGBTQ+ people suffer high levels of bullying and harassment at work, including experiencing a negative or mixed reaction from others, someone disclosing that they were LGBTQ+ without their permission, unspecified inappropriate comments or conduct, and verbal harassment (GEO, 2018). Prevalence of workplace discrimination is higher among

minoritised ethnic LGBTQ+ people, and among trans people (GEO, 2018; Bachmann and Gooch, 2018b).

78. Anticipation of discrimination in employment settings leads to restricted job choice. A report by the Equality and Human Rights Commission shows that 39% of gay men and 33% of lesbian women in England, Scotland and Wales, said there were jobs they would not consider because of their sexual orientation (Ellison and Gunstone, 2009). The most commonly cited jobs and careers that LGB respondents would avoid were the police service and armed forces, teaching, and manual trades.

Discrimination in healthcare settings

79. As described in Topic 2, LGBTQ+ people experience worse outcomes in health and social care, and this is due to high levels of discrimination experienced. Studies have documented reports of discrimination or negative attitudes towards LGBTQ+ people from health professionals (King, 2015). For example, a significant proportion of psychiatrists have actively engaged in treatment with an LGBTQ+ individual with the aim to 'change or reduce their same sex attraction' (King, 2015), despite widespread discreditation of conversion therapies by national professional bodies (RCPsych, 2018). 10% of health and social care staff have witnessed staff within their workplace expressing the belief that someone can be 'cured' of being lesbian, gay or bisexual (Somerville, 2015). Other forms of discrimination include making negative remarks about patients because of their sexuality or gender identity. LGBTQ+ people delay or avoid seeking care due to expectations of discrimination.

Discrimination in housing settings

80. With regard to accessing housing provisions, Stonewall reports that 18% of lesbian, gay and bisexual respondents in Britain expect to be treated worse than heterosexual people when applying for social housing. 25% of LGB people aged 55 and older report this (Hunt and Dick, 2008).

81. In Scotland, Stonewall found that 27% of LGBTQ+ people felt that they would expect to face discrimination from a housing officer were they to apply for social housing. This was reported by 48% of trans people and 40% of disabled LGBTQ+ people (Aldridge and Somerville, 2014).

Discrimination by neighbours and family members

82. 24% of LGBTQ+ people surveyed by the National LGBT Survey were not open about being LGBT with any family members that they lived with (excluding partners), while 65% were open with all or most. 42% of cisgender LGBTQ+ people aged 16-17, and 28% of 18-24 year olds, were not open with any of the family they lived with about their sexual orientation (GEO, 2018). A Survey of housing in Wales conducted by Stonewall Cymru and Triangle Wales (2006) found that 42% of participants felt that their neighbours' reactions and actions towards their sexuality played a significant role in creating and/or sustaining their housing problems. Neighbour abuse, harassment and/or intimidation was the most frequent cause of housing problems among gay men and women over 40. Examples of harassment in or around the home included: verbal abuse, graffiti, vandalism to property and possessions, burglary, physical assault, and arson. LGB people stated that harassment, which was homophobic in

nature, was the main cause of housing problems, and the most significant cause of the need to move or leave home (Stonewall Cymru, 2006).

Discrimination from research and funding infrastructures

83. There is currently a lack of data and research to monitor and understand inequalities for LGBTQ+ people. This gap in data is a result of persistent underinvestment in infrastructure for LGBTQ+ research, which is in itself a form of heterosexism and cisgenderism that further hides and marginalises LGBTQ+ populations.

84. During the pandemic LGBTQ+ research was dismissed by mainstream funding bodies. For example, only 2 in 645 new research awards made by the UKRI COVID-19 research and innovation scheme were awarded to LGBTQ+ projects. This means only 0.13% of the funds awarded went to LGBTQ+ projects (UKRI, 2023).

85. Poor uptake of sexual orientation monitoring across health and social care systems, non-inclusive gender monitoring, and a lack of trans status monitoring in health care records means we don't have a robust evidence base to monitor the existence and magnitude of LGBTQ+ inequalities in health and social care, or any progress in addressing inequalities.

86. In addition, there is currently a dearth of representative population-level survey data, which precludes reliable identification of inequalities in health and social outcomes for LGBTQ+ people, compared to heterosexual and cisgender counterparts. The 2021 Census was the first to ask about sexual orientation and gender identity.

87. In the context of the pandemic, this lack of data meant that it was not possible to monitor trends in infection and outcomes from Covid-19 for LGBTQ+ groups, further masking, and possibly exacerbating, existing inequalities.

Discrimination from public spending

88. In addition to underinvestment in research infrastructure, LGBTQ+ populations suffer from underinvestment in voluntary sector services, which provide specialised support to LGBTQ+ people. As argued in evidence provided by Professors Bambra and Marmot (INQ000195843, point 48), public health budgets and local authority budgets across all four UK countries have been substantially reduced since 2010. Reductions in public spending have resulted in reduced access to some mainstream services (such as GPs, mental health, and sexual health services) and this has resulted in an increased demand on voluntary sector services, at a time when they were also facing cuts (Davies et al., 2016). The combination of public funding with the increased need for culturally appropriate services from LGBTQ+ groups means that cuts in public spending have a disproportionate effect on LGBTQ+ groups, compared to the general population. Members of the LGBTQ+ voluntary sector report they are less of a priority for public and charitable funding, compared to other groups (Davies et al., 2016).

89. A survey of commissioners and providers of services for young people suggests that there is very little targeted provision towards LGBTQ+ youth services. Within England it is estimated that only a minority of areas offer any LGBTQ+ focussed youth services, with limited funding provision, amounting to less than £1 million with most funding being provided through non-statutory sources (Baker et al., 2016).

90. Despite the Government Equalities Office allocating £4.5 million of funding in their 'LGBT Implementation Fund,' persistent austerity, compounded by lack of consideration and support given to LGBTQ+ groups in the pandemic, resulted in voluntary sector organisations providing increased support for this population, at a time when resources were already depleted. This has a strong potential to further exacerbate inequalities experienced by LGBTQ+ populations and the voluntary sector organisations that support them.

Topic 4. Missed Opportunities

91. In this section I outline what anti-heterosexist and anti-cisgenderist approaches to managing the Covid-19 pandemic (and future crises) should have been incorporated. Anti-heterosexist and anti-cisgenderist approaches explicitly consider sexual orientation and gender identity, with an understanding that disregarding them could lead to poor health and social outcomes for LGBTQ+ populations, and further exacerbate existing inequalities.

92. Due to increased prevalence of pre-existing physical and mental health conditions, LGBTQ+ people (particularly LGBTQ+ disabled people, LGBTQ+ minoritised ethnic people, LGBTQ+ youth, and older LGBTQ+ people) should have been identified as a vulnerable group and measures should have been adopted to reduce their risk of infection.

93. PrEP and PEP (medication taken to prevent HIV transmission) should have been provided in a wider range of settings. PrEP and PEP were provided by sexual health clinics and A&E during lockdown, which many LGBTQ+ people do not access for fear of discrimination. Information on how and where to access PrEP and PEP should have been widely disseminated.

94. NPIs to manage the pandemic should have prevented causing further delays to waiting times and difficulties in accessing transition-related care.

95. National and local Governments should have provided adequate funding to support services targeting LGBTQ+ people (including youth groups, mental health support services, homelessness services, and services for older people). National and local Governments should have also engaged with these services throughout the pandemic to gauge demand for support and address any gaps in provision.

96. Services designed to meet the demand created by the pandemic, including with regards to mental health, domestic abuse, youth, housing, homelessness services, and residential care should have been LGBTQ+ inclusive (for example, providing training on LGBTQ+ inclusion to all frontline staff delivering these services).

97. Increased provision of safe housing should have been provided for LGBTQ+ people in unsafe or insecure living situations, such as homophobic or transphobic environments, and for LGBTQ+ people experiencing domestic abuse.

98. The design and implementation of standard pandemic control measures like lockdown and travel restrictions should have considered differences in the characteristics of the networks and sources of social support of LGBTQ+ populations, since these measures are likely to have had a disproportionate impact on LGBTQ+ groups, particularly for older LGBTQ+ people, disabled LGBTQ+ people, and LGBTQ+ people with mental health conditions.

99. Given increased financial precarity, increased economic welfare provision should have been considered for LGBTQ+ groups at increased risk of economic difficulties, including trans people, minoritised ethnic LGBTQ+ people, and disabled LGBTQ+ people.

100. The design and implementation of pandemic control measures should have considered providing access to supportive, safe spaces (both in the community and online) for LGBTQ+

people. This is particularly crucial for LGBTQ+ young and older people, trans people, and LGBTQ+ disabled people.

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Annex 2: Glossary of terms used in the evidence base

Bisexual: People who experience sexual or romantic attraction to people of their own gender and toward another gender.

Cisgender: A term used to describe people whose gender identity is congruent with what is traditionally expected on the basis of their sex assigned at birth.

Cisgenderism: A system that oppresses, denigrates and pathologises self-identified gender identities that do not align with assigned gender at birth as well as resulting behaviour, expression, and community (Ansara and Hegarty, 2012).

Gay: A term used to describe men who are romantically or sexually attracted to men.

Heterosexism: A system that structures societal institutions, policies, practices, norms and values based on the assumption that everyone identifies as heterosexual. Heterosexism denies, denigrates, and stigmatises any form of identity, behaviour, relationship, or community that is not heterosexual (Herek, 1990).

Lesbian: Term used to describe women who are romantically or sexually attracted to women.

Men who have sex with men (MSM): Men who do not identify as a sexual minority, but who engage in sexual activity with other men.

Queer: Term used to represent all individuals who identify outside of other categories of sexual and gender identity. Queer may also be used by individuals who feel other sexual or gender identity labels do not adequately describe their experience.

Sexual minority: People who have a sexual orientation that is anything other than heterosexual/straight. It typically includes gay, bisexual, lesbian, queer, or something else. Sexual orientation is different, and independent of gender identity.

Trans: An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.