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Cite this as: *BMJ* 2021;372:m4828
http://dx.doi.org/10.1136/bmj.m4828
Published: 16 March 2021

LGBTQ+ HEALTHCARE

How covid-19 has exacerbated LGBTQ+ health inequalities

Despite inadequate monitoring of health in the LGBTQ+ community, the data we have suggest a disproportionate effect of the covid pandemic and its control measures, writes Callum Phillips

Callum Phillips *BMJ Clegg scholar*

"Wherever you meaningfully look for LGBTQ+ health inequalities, you find them," says Michael Brady, national adviser for LGBT health at NHS England. "And yet we're still not properly looking."

In 2018 the UK government published an LGBT action plan, aiming to ensure that "LGBT people's needs are at the heart of the National Health Service."[1] Despite this executive recognition of the physical and mental health inequalities faced by the LGBTQ+ community—as well as the inequities in access to care and the social determinants of health—three years on, the UK still doesn't routinely monitor sexual orientation or gender identity at a national level. And yet the data we do have suggest that covid-19 has exacerbated these disparities, highlighting the shortcomings in this monitoring and our approach to LGBTQ+ healthcare.

The lack of national data is a fundamental stumbling block to fully understanding the impact of the covid pandemic, including control measures, on LGBTQ+ people. Brady tells *The BMJ*, "The Office for National Statistics talks about religion, ethnicity, postcode, deprivation, and age because that [information] is all routinely collected, but LGBT individuals are invisible."

The data that are available show baseline physical health inequity: for example, trans and non-binary people are more likely to be disabled and to have chronic health conditions,[2] and lesbian and bisexual women are more likely to be obese.[3] In the Women and Equalities Committee's 2019 report, Justin Varney suggested that higher rates of smoking and alcohol consumption made LGBTQ+ people more likely to be affected by cardiovascular disease, certain cancers, and respiratory illness—but he warned that, without mandatory national collection of routine data, these health disparities would occur within a minority blind spot.

These are all poor prognostic factors for covid-19, yet the lack of monitoring makes it unlikely that we'll ever know if they had a disproportionate physical impact. Varney recommended introducing monitoring within 12 months of the report, adding that "any service provider who does not implement it should face fines at a level equivalent to those imposed for not monitoring ethnicity."[4]

The failure to have already implemented such monitoring is a combination of several factors. Brady says that these include "infrastructural issues, such as IT systems not set up to record these data, and competing system pressures." He adds, "There are also challenges to address in terms of attitude and awareness about why sexual orientation is relevant to patients' care or may impact on the inequalities they experience."

Mental health and support networks

Mental health is one of the better covered areas: effective monitoring has clearly shown that the starting point of LGBTQ+ mental health is significantly lower than in the general population, as over 52% of LGBT people had experienced depression in the past year and a similar proportion had self-harmed or considered taking their own life.[5] In minority ethnic groups and in trans or non-binary people these proportions were 64% and 70%, respectively.[6] By contrast, 20% of adults nationwide have been affected by a mood disorder needing treatment, and less than 5% of the general public have considered ending their life.[7]

Lockdown and social distancing during the covid-19 pandemic have worsened the nation's mental health: a Nuffield Health survey reported that 80% of British people working from home had felt the negative impacts of lockdown.[8] But this impact has not been felt equally: for example, self-harming among gender diverse people has increased by 7%, compared with 2% in cis-gendered people. In the same period, the 34% of LGBTQ+ people reporting "poor" or "extremely poor" mental health has almost doubled to 61%. The report found similar increases in experiences of depression and anxiety "very often" or "every day," and gender diverse and ethnic minorities were particularly affected.[5]

One possible reason for this is how support systems for the LGBTQ+ community often differ from those for cis-gender and cis-heterosexual people. The term "chosen family" is often used to describe the communities that LGBTQ+ people choose to forge, and evidence has shown the strength of these groups. They operate as a safeguard against depression and suicidality caused by stigma and discrimination,[9] and—particularly among young LGBTQ+ people—these connections may be more effective at reducing poor mental health than even individualised approaches such as cognitive behavioural therapy.[10,11]

Loneliness and social isolation have been linked to an extensive list of higher risks for a number of physical and mental conditions, including increases in overall mortality, heart disease, stroke, hypertension, and dementia.[12] In the LGBTQ+ community loneliness has more than doubled during

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lockdown, rising to 56% experiencing it "very often" or "every day."[5] This includes more than two in three respondents aged under 18.

Elderly people who are isolated and often rely on their chosen families for practical support are likely to have been cut off from these networks, without easy alternatives. While many elderly people have faced difficulties with shielding and loss of support networks, there's a disproportionate impact on LGBTQ+ individuals: 52% of gay men aged over 50 live alone, compared with just 19% of heterosexual men over 50.[13] The LGBT Foundation has reported that older LGBTQ+ people are extremely reliant on their chosen families for practical support, such as shopping and medicine deliveries,[14] but often don't live with them.

However, Sophie Quinney, a GP with a special interest in trans health, says that trans people tend to have an online presence—having to look to the internet for comfort and affirmation, whether that be through forums, cosplay (costume play), or gaming communities.

LGBT phobia

For many, the alternative to isolation is an unsafe home environment: 8% of LGBTQ+ people don't believe that they have a safe place to live during lockdown.[14] LGBTQ+ people are more likely to face domestic abuse,[15] and the charity Refuge reports a 10-fold increase in cases throughout the UK generally.[16] In OutLife's *LGBTQ+ Lockdown Wellbeing Report*, 15% of LGBTQ+ people reported experiencing violence or abuse during lockdown, and black and south Asian LGBTQ+ people were more than twice as likely to have experienced it.[5]

Lockdown, self-isolation, and social distancing also make it difficult to seek confidential support, as living with LGBT-phobic people can make it risky to seek help. There was no track record of success before the pandemic: 10% of LGBT and 25% of trans people had been outed without their consent by healthcare staff.[6] However, Quinney says that she's seen benefits from remote access for those with geographical, financial or health limitations.

Brady explains, "Having to lock down with a phobic family when you're also separated from your community, your LGBT venue, or trans friends—or the lack of information about where and how to get support, and the loss of services that have shut down or only have phone or online support—it's a double whammy."

Disparities have also arisen in access to healthcare during lockdown. Nearly 40% of LGBT people report missing appointments, peaking at around 50% of trans people, compared with 35% of cis people.[5] Stewart O'Callaghan, founder of the LGBT cancer charity Live Through This, says that particular concerns for trans people are distress caused by delays to top surgery (gender mastectomy), a lack of access to gender affirming hormone treatment, complications regarding chemotherapy while taking these hormones, and the already long clinic waiting lists, which Brady acknowledges have worsened during lockdown.

Opportunity for change

Brady has been impressed by the way the LGBT voluntary sector has stepped up during the pandemic, with increased service offers, information provision, and general support, despite the financial hits charities have taken in lockdown.[17] It's no surprise, he says, that "two thirds of LGBT people would prefer to access services provided by a dedicated LGBT organisation."

Where he's seen good NHS practice, it's often been delivered in partnership with these very services or with their significant input. Brady hopes that this kind of partnership will become more common as we transition back to normal service. He suggests that existing services, including general practices, can use the more regular update of websites with service and covid information, to update imagery and provide LGBTQ+ representation, to include these patient groups in feedback surveys, and to monitor how many LGBTQ+ patients use the services. "Doctors have power over the information we write for our patients, the information on our websites, and the posters in our waiting rooms," he says. "These are the really simple things individuals can do."

Brady also hopes that, by acknowledging that covid has highlighted and exacerbated existing social and health inequalities, opportunities exist for tackling them. It's time to get comfortable, he says, with asking about gender identity and sexual orientation as routinely as we do about age, postcodes, and disabilities. While systemic rollout of monitoring will be fundamental to overcoming disparities and reducing the erroneous assumptions that negatively affect patients' experiences and outcomes, some responsibility still lies with the individual doctor.

"If you aren't asking questions about sexual orientation and gender identity, you're already excluding an individual," he explains. "We like to talk about patient centred care and a holistic approach, but you can't provide that if you don't know the fundamental things about an individual—which affect their comfort with you, how they interact, and their response to your treatment plan."

During the first UK lockdown in March 2020 Quinney produced a 10 minute video on trans healthcare,[18] available from Health Education and Improvement Wales. She encourages doctors not to place the burden on patients regarding person centred care, to ask about patients' pronouns, and not to make assumptions or take a heteronormative approach. This is especially important, she says, because during phone consultations a doctor may not recognise the voice of who they're expecting to speak to, having made a presumption of how the patient will sound.

She concludes, "It really is the simple things, the easy things, that determine whether people take the next steps in accessing their healthcare provider."

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned, not externally peer reviewed.

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