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# Review of Evidence of Inequalities in Access to Health Services in Wales and the UK: Gender, Gender Reassignment, and Sexual Identity - Summary report

# Summary report - Review of Evidence of Inequalities in Access to Health Services in Wales and the UK: Gender, Gender Reassignment, and Sexual Identity


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## ESRC PhD Internship Programme



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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government


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## Acronyms

| | |
|---|---|
| BME | Black and minority ethnic |
| Bpas | British Pregnancy Advisory Service |
| CEMACE | Centre for Maternal and Child Enquiries |
| CEMACH | The Confidential Enquiry into Maternal and Child Health |
| EHRC | Equality and Human Rights Commission |
| GP | General Practitioner |
| LGB | Lesbian, Gay and Bisexual |
| LHB | Local Health Board |
| T | Transsexual |

# Executive Summary[1]

### Background

This report seeks to review and synthesise the body of evidence on inequalities and inequities in access to health services that are associated with characteristics of gender, sexual identity and gender reassignment. It is envisaged as the first part of a full review of inequalities of access to health services that will form a foundation for the development of interventions and the sharing of good practice.

This review is based only on published evidence for inequalities in Wales and the UK and does not review current practice.

## *Primary Care Services*

There is more research that relates to inequalities of access to primary care services compared to other areas. In addition, the evidence is mainly based on larger samples of the population, with the notable exception of data for Lesbian, Gay, Bisexual and Trans people. Though we can be less confident in the reliability of this data for these latter groups, we have significantly greater knowledge about the experiences of LGB and Trans people than has been included in previous reviews.

Although consultation rates differ for women and men in the UK, with women being more likely than men to access their GP or practice nurse, evidence suggests that there are only minor differences in their preferences in how to access or book GP surgery services. Men are only slightly less likely than women to state that they have a preferred GP, prefer same-day appointments or that their surgery's opening times are convenient for them. Women and men are as likely to say that they would like additional opening hours, in particular after 6:30pm and at the weekend. Men continue to be less likely than women to use NHS Direct services despite agreeing that they are convenient. Evidence for gender differences in help-seeking is conflicting and inconclusive.

Relying on public transport may pose a barrier to accessing health services as it is less convenient than private transport, particularly for disabled people or people travelling with children. There is some evidence to suggest that particular women may feel unsafe.

It is difficult to collect robust statistical data for Trans people in Wales and the rest of the UK, though there is data available thanks to a larger survey

[1] The points presented here reflect conclusions shown in the literature. This does not exclude the possibility that similar issues affect further groups of people not yet been demonstrated through research, for example, some of the issues affecting LGB people with regards to assumptions about their care needs, or fear of prejudice, may also affect Trans people.

conducted recently and further data relating to their experiences of health services (**see Gender Reassignment**). Trans people may face barriers to accessing 'safe-spaces' such as community group meetings due to working hours and lack of non-gendered facilities. Sixty five per cent of Trans people report experiencing 'negative interactions' within general health services.

Lesbian, Gay or Bisexual people have less confidence in their GPs than straight people and report poorer experiences of consultations. Only a quarter of LGB people felt they had received advice that was relevant to their sexual identity. Some feel that they have had no opportunity to disclose their sexual identity to a health professional or would fear doing so. There is strong support for the development of 'safe-spaces' for LGB and Trans people in which to receive health advice. The most vulnerable people in these groups would prefer to consult a specialist GP.

## *Referral and Records*

There are indications that the process of changing an individual's biological sex and name on their medical record is inconsistent for people undergoing gender reassignment. This can cause great distress to individuals and the repercussions of this can 'out' them, for example through wrongly or dual addressed letters.

When consulting LGB people, health professionals can sometimes make inappropriate assumptions about their patient's health needs based on their sexual identity.

There is also only a small amount of research on whether men and women, who present with the same symptoms, are treated or referred differently because of their sex. Evidence in this area remains contradictory and inconclusive.

## *Intersections*

The quality of evidence for 'intersectional' disadvantage is varying.[2] Statistics from the GP Patient Survey 2011-2012 give us reliable information about usage for BME groups. Smaller pieces of evidence that inform us about other minority groups are less robust but can be used to highlight relevant concerns.

*Ethnicity:* Looking at the GP Patient Survey for 2011-2012, people from Black or ethnic minority backgrounds (BME) are more likely than white people to have never seen their GP or practice nurse. BME men are more likely than

[2] Disadvantage may be 'intersectional' when an individual's adverse experience is associated with more than one characteristic. It may be that disadvantage arises as a result of a particular combination of characteristics or that disadvantage that is associated with each of the characteristics is compounded.

any other group to report that usually only one GP is available at their surgery. BME men are more likely than white men to say that they have accessed out-of-hours services in the last 6 months. Other evidence suggests that the sex of the GP or nurse may represent a barrier to access for Gypsy or Traveller people and language barriers among some BME groups may impede understanding of health advice.

*Age:* Older LGB people are more likely to say that they will need to rely on care services in later life, but some express fears of prejudice from carers and that disclosure of their sexual identity may adversely affect their care. There is limited evidence that adolescent girls report lower self-esteem than boys.

*Disability:* LGB disabled people also report concerns about care staff prejudice and maltreatment. Women and younger disabled people are more likely to report barriers to accessing healthcare, but the reasons for this are unclear.

Other marginalised or vulnerable groups such as homeless people, those fleeing from domestic abuse, or lone parents may have reduced access to health services due to lack of transport, the cost of reaching services, or difficulty finding alternative childcare.

## *Pregnancy and Maternity*

Evidence in this area comes from small-scale studies that give us insights into issues for further research.

*Ethnicity:* Women from BME backgrounds are more likely to book late for antenatal care and language barriers among some groups may impede understanding of health advice. Women's preferences for interpreters can be complex: some experience difficulties accessing professional interpreters or experience discomfort with interpreters they do not know, preferring friends and family to interpret. Yet, for others this can compromise their ability to communicate sensitive information or emotions in an open manner.

There is some evidence that health professionals can make assumptions about patient preferences or health needs based on ethnicity and that these can be inappropriate. Refugees and asylum seekers appear to be particularly vulnerable and face multiple barriers to access, including: lack of interpreters, lack of knowledge among health professionals about Female Genital Mutilation, mixed-sex services, difficulties registering with a GP, lack of understanding of UK healthcare procedures and organisational structure, and accessing low-income benefits.

*Sexual Identity and Trans*

Same-sex parents or co-parents[3] may be reluctant to disclose their family status to health professionals, and report mixed experiences of whether they feel included by maternity professionals. They may also experience difficulties accessing relevant information and support.

During the time available for this research, no studies on experiences of UK services of Trans parents were found. Further work is needed to identify whether this represents a genuine research gap, or simply insufficient time to identify in this review.

*Age:* Local evidence suggests that some younger parents feel stigmatised by health services because of their age. Young fathers can feel uncomfortable attending antenatal classes and marginalised during check-ups. Some young men also report that they find it difficult to attend appointments, because they cannot secure time off from work/education. Evidence for inequality regarding young women's access to abortion services is unclear, but there has been an indication that the NHS is less likely to carry out abortions after 13 weeks than at private clinics. This has the potential to cause inequality in access to abortion services, particularly for those who rely on public transport.

*Disability:* Disabled people may experience lack of accessible equipment or facilities for postnatal care in hospitals.

## *Sexual Health*

Much of the information in this area comes from local studies. Lack of ability to generalise for the whole population may be considered a concern regarding data for larger populations such as women and men; however, for minority or 'hidden' populations data can be difficult to obtain.

For young men, it has been suggested that opening hours of GUM clinics and reliance on public transport may pose a barrier to accessing sexual health services, along with peer pressure and concerns about confidentiality.

Fifteen per cent of Lesbian or Bisexual women have never been offered a smear test and there is a perception among LGB people that there is little visible information about LGB sexual health. LGB people report that health professionals sometimes make inappropriate assumptions about their sexual health needs and that sexual health risks for LGB people are not fully understood by all health professionals. Bisexual people are least likely of all to agree that health information caters for all groups. Trans people are most likely to disagree that health information is appropriate to their identity or sexual identity.

[3] The term 'co-parenting' describes a context where the parents are not in a marriage, cohabitation or romantic relationship with one another.

Some BME women may find it more difficult than women of white background to talk with friends and family about sexual health, pregnancy and abortion, and may also perceive that health services do not appreciate cultural differences.

## *Cancer Treatment*

Some large surveys offer us robust evidence of inequalities of experience of cancer treatment and screening services. However, it is important to remember that research that asks about attitudes and perceptions often tell us about social and cultural *norms*. Though interviews and self-reporting surveys are an often necessary and convenient method of collecting data, we should be wary of inferring a direct relationship between perceptions and behaviour.

Women are more likely than men to have access to a Clinical Nurse Specialist (CNS). Having access to a CNS is associated with increased satisfaction of cancer treatment. Yet, men are generally more positive than women about their experience of cancer treatment: especially regarding staff attitudes, privacy, provision of sufficient information, and being treated with dignity and respect.

The association between level of knowledge about colorectal cancer screening and having negative attitudes is inconclusive: whilst men are slightly more fatalistic in attitude towards bowel cancer than women, they are more likely to report that they 'never feel frightened' at health appointments. Women express greater levels of disgust and embarrassment about the bowel cancer screening procedure.

Some evidence suggests that men's partners may be influential in them taking action on health issues.

## *Exercise and Weight*

There are few sources of evidence for inequalities in access to exercise and weight-management services. The data on these areas cannot be considered robust but only an indication of the issues.

LGB and Trans people express a fear of prejudice that may discourage them from exercising in public spaces.

Women are more frequently recorded as obese by their GPs but also are more likely to consult for problems with eating. The relationships between norms of 'masculinity' and exercise/food are complex and differ significantly between various masculine ideals.

## *Alcohol and Smoking*

There are inequalities between men and women, not only in the rates of referral for substance misuse, but also in mode of referral. There is very little other robust evidence in this area and some of the conclusions from the data are conflicting: the relationship between alcohol tolerance and sex is unclear and there is a lack of robust evidence for gendered attitudes towards and usage of alcohol and smoking.

There is some evidence that prior to the regulations on smoking in public places, Lesbian or Bisexual women were less likely to want to give up smoking than Gay or Bisexual men or people identifying as an 'other' gender. It was not possible in the time available for this research to identify comparable studies conducted after the introduction of these measures.

## *Gender Reassignment*

We are not able to estimate the number of people who identify as 'Trans', or the number of people who may wish to undergo gender reassignment but who have not yet begun the process, and so data relating to this population cannot tell us the prevalence of particular problems in relation to the wider population. However, the evidence that does exist is detailed and a good indication of the issues that Transsexual people might face.

Some people experience difficulties in getting GPs to refer them for gender reassignment services and some GPs are not fully informed about gender reassignment processes or refuse treatment. There are gaps in provision of certain services in Wales. There is strong support for more local services and GPs specialising in Trans health needs. Satisfaction with Gender Identity Clinics is extremely varied and a high number of Trans people report having experienced negative interactions in this setting. Some Trans people report withholding information or lying at Gender Identity Clinics due to perceived irrelevance of questions or fear that treatment will be delayed or withheld.

Criteria for qualifying for gender reassignment may not be consistent among local health authorities. A minority of Trans people feel adversely affected as a result of health staff prejudice. Up to 59% of people undergoing gender reassignment are not entirely happy with the support they received from surgery or nursing staff. This figure may be higher for public health services.[4]

It is generally not possible to move between Gender Identity Clinics if you move away from the area: this may prove a barrier for people relying on public transport or who have limited funds.[5]

[4] A new standard Gender Dysphoria care pathway has recently been developed in Wales that is likely to address some of the problems raised.
[5] *Ibid.*

## *Prison*

Evidence for inequalities in access to health service whilst in prison is available from few sources: these consist of studies and policies commissioned or produced by various government departments.

Prisoners who have experienced gender-based violence may need special health care provision and pregnant women who arrive in prison may have had unequal access to services previous to admission and subsequently have different health needs whilst an inmate.

Some details of provisions that are available to prisoners undergoing gender reassignment remain ambiguous. There is a lack of evidence on the experiences or safety of prisoners undergoing gender reassignment and a need to monitor the implementation of guidance.

## *Mental Health*

The small amount of data on the subject of usage of mental health services is more robust than the majority of the research that discusses attitudes towards mental health. However, as outlined above, caution needs to be exercised in making any connection between attitudes expressed by participants in research and patient behaviour.

Men are more likely than women to be formally referred to NHS mental health services or to be admitted to independent hospitals, whereas women have higher rates of informal admission. Men may be more likely than women to find themselves in situations that put them at risk of mental illness. From attitudinal studies, some men express concern at the availability of information about mental health and urgent help. Some report difficulties discussing their mental health with a GP and would prefer to consult a specialist GP (though these data are not compared with those for women). Men express slightly less tolerant attitudes towards people with mental health issues, but are more likely to believe that people can completely recover.

Women with mental health issues may not feel comfortable in mixed-sex services.

Rates of detention in medium and high security wards are higher for BME people and Black African and Black Caribbean men are more likely to be in receipt of mental health services compared to white men. There are concerns among some BME groups over the cultural sensitivity of mental health services.

LGB and Trans people who have mental health difficulties are more likely to report that they have felt uncomfortable using mainstream services and a majority report experiences of negative interactions within this setting. Almost

a third of Trans people who have used mental health services report feeling that their gender identity was not seen as valid but as a symptom of mental ill-health. Thirty eight per cent of Trans people who have been inpatients have experienced problems such as harassment, misgendering or uncertainty as to where they will be placed within single-sex facilities.

## *Pharmacies*

Only a handful of studies have looked at the issue of pharmacy use and more data is needed in this area for policy development: it seems that only a small proportion of men visit pharmacies for general health advice. Contrary to some hypotheses about self-treatment among men, men may be slightly less likely than women to buy over-the-counter medicines. Pharmacies are often used for medical advice when GPs' time is deemed to be 'too valuable' to spend on minor health issues, and when pharmacists are believed to be qualified to diagnose illness.

## *Further services and intersections*

This section includes evidence of inequalities in access to services that have not yet been included, or that are associated with two or more protected characteristics including gender, gender reassignment or sexual identity. Much of the data for further intersectional disadvantage and services is based on small-scale investigations. This evidence should be regarded as a window into the issues that people may face when accessing health services and a sensitising tool in the development of interventions.

There is some evidence that assumptions may be made about an individual's ability to care for a relative or partner based on their sexual identity. Older LGB and Trans people may fear discrimination and abuse from care providers. Bisexual people may have health needs that are not addressed by mainstream, Lesbian or Gay-specific services.

For some, lack of disabled access and long waiting times may be a barrier to accessing mental health services and women with learning disabilities may have reduced access to support during the menopause.

People who are divorced or widowed are more likely to experience mental health difficulties.

## *The Law*

There is little evidence on this topic, but we may be confident in that some legal difficulties remain for people who undergo gender reassignment: transsexual people who are married may need to divorce and then obtain a

civil partnership in order to obtain their Gender Recognition Certificate. There are indications in research that this process can be distressing.

Although the methods used to obtain evidence of concerns expressed by LGB people are not always robust, it echoes worries about lack of understanding and/or prejudice towards sexual minority people in other areas of health service. A small number of LGB people have expressed concern that health professionals may not be able to identify their next of kin in an emergency.

## *Respect and Dignity*

As with other areas of evidence in this review, the methods used to gather data from minority groups are not always as robust as would be preferred for the development of policy or interventions. Attitude surveys also present challenges to interpretation, as outlined previously. However, the experiences reported do raise important issues of inequity that should not be ignored.

According to the only study in this area, one in seven Trans people report feeling treated adversely by health professionals and there are reports that some Trans people are placed in hospital wards that are inappropriate for their sex. Similarly, Intersex people are not always included in appropriate screening programmes.

In some cases, health professionals insist on procedures that are not relevant to LGB people. A minority of LGB people in Wales report negative experiences of health care and a minority of LGB people would not register their same-sex partner as next-of-kin for fear that their care would be adversely affected.

Health professionals can make inappropriate assumptions about the fertility or pain management preferences and needs of BME women.

In the only study that could be located on this issue, NHS-provided abortion services receive more negative feedback on how supportive services are for young women compared with specialist providers such as Marie Stopes or British Pregnancy Advisory Service (bpas).

## Recommendations – Next steps

*1. Complete Review of Protected Characteristics*

In the endeavour to reduce inequality, it is important to make recommendations based on this review *and* a review of the remaining protected characteristics and issues that have not been discussed in this report. Many issues, for example communication with patients, will be cross-cutting.

*2. Review Interventions and Develop Case Studies to Share Good Practice*

It is possible that some of the operational-level suggestions made here are already being implemented by some practitioners or Local Health Boards (LHBs) within Wales. Examples of good practice need to be identified and more systematically shared across Wales, for example, by making case studies available.