Older Lesbian, Gay and Bisexual People: Health and Healthcare Inequalities.  

Introduction

This submission addresses health inequalities among older lesbian, gay and bisexual people, who experience inequalities associated with both LGB issues and ageing. I am an academic who researches these issues and has published widely on them. As I have previously written:

In countries where there is a lack of legal recognition and social protections, the health of LGBT people is impacted not only by the accumulated effects of discrimination but also by the fact that their older age care needs are served by health and social care systems that offer little or no recognition of their minority identities (AGE Platform Europe and ILGA-Europe, 2012). Even in more liberal countries offering some forms of legal rights, older LGBT people experience a range of health inequalities. These disadvantages (Fredriksen-Goldsen et al, 2013a, 2013b) can be clustered into four main areas:

- the cumulative physical and psychological effects of discrimination, stigma and marginalisation across the lifecourse;
- a relative lack of social capital, particularly informal social support, compared with heterosexual and cisgender older people;
- health and social care provision that is ill-equipped to recognise and meet the needs of older LGBT people;
- the intersection between increased need for formal support and a reluctance on the part of older LGBT people to access health and social care provision because of concerns about how they will be treated.

(Westwood et al, 2015, 146)

Health concerns

There is a now a strong body of knowledge which now indicates that older LGB people have poorer health than older non-LGB people (Fredriksen-Goldsen et al, 2013). According to the largest UK LGBT advocacy organisation, Stonewall (Ashworth, 2013):

- Lesbian and bisexual women are twice as likely to have never had a cervical smear test, compared with women in general
- One in five lesbian and bisexual women have deliberately harmed themselves in the last year, compared to 0.4 per cent of the general population
- Half of lesbian and bisexual women are not out to their GP
- Three per cent of gay and bisexual men have attempted to take their life in the last year, compared to just 0.4 per cent of men in general
- Half of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16
- One in four gay and bisexual men have never been tested for sexually transmitted infections

Older LGB people are particularly disadvantaged in relation to health and wellbeing. A UK survey of over 1,000 older LGB and 1,000 older heterosexual people, also commissioned by Stonewall (Guasp, 2011, 3) reported that older LGB people:
• Drink alcohol more often. 45 per cent drink alcohol at least ‘three or four days’ a week compared to just 31 per cent of heterosexual people.
• Are more likely to take drugs. 1 in 11 have taken drugs within the last year compared to 1 in 50 heterosexual people.
• Are more likely to have a history of mental ill health and have more concerns about their mental health in the future.
• Lesbian and bisexual women are more likely to have ever been diagnosed with depression and anxiety – two in five have been diagnosed with depression, one in three with anxiety.
• Gay and bisexual men are twice as likely to have ever been diagnosed with depression and anxiety than heterosexual men.
• 49 per cent of lesbian, gay and bisexual people worry about their mental health compared to 37 per cent of heterosexual people.

Reporting on a cross-sectional survey of over 2,400 older LGB adults in the USA, Fredriksen-Goldsen et al (2017) identified several risk and protective factors in relation to health and wellbeing:

The findings revealed that lifetime victimization, financial barriers to health care, obesity, and limited physical activity independently and significantly accounted for poor general health, disability, and depression among LGB older adults. Internalized stigma was also a significant predictor of disability and depression. Social support and social network size served as protective factors, decreasing the odds of poor general health, disability, and depression. (664)

Because of minority stress-related health needs and comparatively lower levels of intergenerational social support, as well as the consequences of the AIDS crisis for gay and bisexual men (Hughes and Robinson, 2018), many older LGB people require formal health and social care support sooner and disproportionately when compared with their heterosexual peers (Westwood et al, 2015). As Stonewall (Guasp, 2011, 3) have reported in the UK,

With diminished support networks in comparison to their heterosexual peers, more lesbian, gay and bisexual people expect they will need to rely on formal support services as they get older. Lesbian, gay and bisexual people are nearly twice as likely as their heterosexual peers to expect to rely on a range of external services, including GPs, health and social care services and paid help.

Yet at the same time health and social care providers would appear to be under-prepared to meet the needs of older LGB people.

**Healthcare provision**

**Mainstream services**

A recent UK study commissioned by Stonewall (Somerville, 2015), echoing findings from international studies (e.g. Haesler, Bauer, & Fetherstonhaugh, 2016) identified a range of ‘unhealthy attitudes’ towards LGB people reported by staff working in healthcare contexts. These involved bullying and harassment, a failure to advocate for patients, being ill-equipped to speak up and unequipped to challenge prejudice. In terms of bullying and harassment:

Legal protections have been in place for over a decade but LGBT staff and patients continue to experience discrimination, abuse and bullying.
• A quarter (24 per cent) of patient-facing staff have heard their colleagues make negative remarks about lesbian, gay or bisexual people, or use discriminatory language like ‘poof’ or ‘dyke’, whilst at work in the last five years…
• One in twenty (five per cent) patient-facing staff have witnessed other colleagues discriminate against or provide a patient or service user with poorer treatment because they are lesbian, gay or bisexual in the last five years…
• A quarter (26 per cent) of lesbian, gay and bisexual staff say they have personally experienced bullying or poor treatment from colleagues in the last five years as a result of their sexual orientation.

(Somerville, 2015, 3).

These ‘unhealthy attitudes’ are compounded in older age care health and social care provision, which can ignore older people’s sexualities and/or assume heterosexuality (Westwood, 2015; Simpson, Almack and Walthery, 2016).

Services for older people

Older age healthcare and social care provisions often overlap, for three main reasons Firstly, many older people with age-related health issues also have associated social care needs. Secondly many older people with age-related cognitive and/or physical disabilities are cared for in social care settings, i.e. residential care/care with nursing homes. Thirdly, and perhaps most significantly, age-related dementia, despite being organically-based, is treated in UK policy (and funding) as a social, rather than a medical problem.

There is now general recognition in the literature that older-age care spaces are ill-equipped to meet the needs of older LGB people, being sites of heteronormativity (the assumption that heterosexuality is the norm) and heterosexism (the privileging of heterosexuality) at best, and sites of prejudice and discrimination at worse (Mahieu, Cavolo & Gastmans, 2018). Older LGB people perceive older age care spaces as spatial locations where they either lack visibility or where visibility is ‘risky’ (Westwood 2015). They are also concerned that they will not be able to be as open about themselves and their relationships as older heterosexual people are, and that they may have to live alongside staff, older people and/or their families and friends who hold disparaging attitudes towards minority sexualities.

Many older LGB people also fear that they will be less able to navigate homophobia and biphobia in such contexts, due to age-related cognitive and/or physical disabilities and reliance upon staff to meet their everyday needs. There are concerns about religious staff who hold negative attitudes towards LGB people (Westwood, 2017). For example, writing in England, Sally Knocker reported,

One older disabled lesbian woman describes being given leaflets by religious care workers suggesting that she could be ‘saved’; an experience that has made her feel unsafe and alienated. (Knocker, 2013, 10)

Because of concerns about staff/peer attitudes, many older LGB people ‘go back in the closet’ (or never come out of it). For example, from my own research, Agnes, who is blind, and identifies as lesbian, is not ‘out’ to the nursing/support staff where she lives:
‘What if they [care staff] took a dislike to me? I don’t think many people here would understand it or accept it somehow’. (Agnes, aged 92) (Westwood, 2016a, 92)

Neither is Frank, who identifies as being gay:

‘I do not need what might be a headache or provoke an adverse reaction’. (Frank, aged 70) (Westwood, 2016a, 92)

The Stonewall-commissioned study which compared 1,000 older LGB people with 1,000 non-LGB older people in the UK (Guasp, 2011, 3) reported that, among older LGB people:

- Three in five are not confident that social care and support services, like paid carers, or housing services would be able to understand and meet their needs.
- More than two in five are not confident that mental health services would be able to understand and meet their needs.
- One in six are not confident that their GP and other health services would be able to understand and meet their needs.

As a result, nearly half would be uncomfortable being out to care home staff, a third would be uncomfortable being out to a housing provider, hospital staff or a paid carer, and approximately one in five wouldn’t feel comfortable disclosing their sexual orientation to their GP.

Significant numbers of disabled lesbian, gay and bisexual people also report that they have not accessed the health, mental health and social care services in the last year that they felt they needed.

As a result of avoiding health and social care support when they need it many older LGB people suffer alone and/or only receive support when they are already in crisis, which can lead to inequitable health outcomes.

**Dementia services**

The lives, needs and experiences of LGB people living with dementia are under-recognised and under-researched (Westwood and Price, 2016). Lesbians and bisexual women are an especially under-identified and under-researched group, at heightened risk of exposure to inadequacies in healthcare, especially older age and/or dementia care (because women live longer than men and have higher rates of age-related dementia) (Westwood, 2013, 2015).

Older LGB people, especially older lesbians and bisexual women, experience comparatively poorer diagnosis, treatment and care, compared with non-LGB people. This applies both to those countries where there are legal recognitions and protections for gender/sexuality minorities (Ward, 2016), and those where there are not and/or are where there are only partial legal rights (Knauer, 2016). This is due to both insufficient informal social support (which might promote the seeking of a diagnosis) and the avoidance of healthcare provision by older LGB people, due to concerns about, heteronormativity, homophobia and biphobia. Moreover, in previous decades, older LGB people were treated as mentally ill because of their sexualities. Many were institutionalised and treated with draconian gay ‘cures’. This can make them very wary of engaging with healthcare, especially mental health care, institutions in later life (Westwood, 2016b, 1499), resulting in delayed diagnosis, treatment and care. Older LGB people may also withdraw from care and support in the community if it is not respectful, leading to premature admissions to nursing home care:
An older gay man with dementia decided to stop receiving services because of the homophobic reaction of care staff. This had led to him having to move into residential care earlier than necessary as his elderly partner had struggled to cope alone with caring responsibilities. (EHRC, 2011, 37)

In addition to their general fears and concerns about older age care provision, especially residential/nursing home care, older LGB people are also concerned about dementia-specific issues. While many people fear age-related dementia, this is heightened for older LGB people who fear the erasure of their identities and histories and ignoring of their most important relationships by dementia service providers (Hughes, 2016). All-important memory work will be ineffective and/or potentially unsafe if older LGB people are unable to be open about their histories and/or cannot shield them from a homophobic audience, and/or they are not able to access their support networks.

If I’m in a sheltered unit or an old people’s home, I want to be able to read and get information and I want to be able to connect with my community. I want to go to [older lesbian group] still. Now how am I going to get to [older lesbian group] if my mobility is compromised? Is somebody going to get me a special bus? If I’m lucky I’ll have friends who’ll take me there once a month. But what if I have Alzheimer’s? Will it be assumed I’m heterosexual and I don’t need my friends to come and talk to me about my past? (Diana, aged 69) (Westwood, 2016a, 146)

**Palliative and end-of-life care**

There is a growing body of literature in the UK and internationally, on inequalities in end of life care for LGB people, which particularly affect older LGB people (Harding et al., 2012). LGB people may avoid, delay or defer accessing palliative care provision due to concerns about prejudice and discrimination and/or non-recognition of their lives, identities and significant relationships. Describing the findings from a large-scale study with older LGBT people in the UK, the National Council for Palliative Care (NCPC, 2012) recently reported:

The findings from the survey reveal that some LGB&T people do not feel that end of life care services are open to them and/or are concerned that they will face discrimination and a lack of understanding from health and social care providers when they are dying, resulting in them not disclosing their sexual or gender identity. Not being able to be open about who you are in the last few months of life can be hugely upsetting and may mean that LGB&T people are not surrounded by their loved ones during their last few months of life and at the time of their death.

In terms of improvements, the NCPC report identified the need for end-of-life service providers to focus on ‘eliminating unconscious assumptions and behaviours which may make LGB people feel less inclined to approach, use or feel comfortable using palliative care services’, ‘changing language & avoiding the heterosexual assumption’ and addressing ‘misunderstanding about “next of kin”’ (see the following section on recognition for more on this). Notably, the NCPC report observed that ‘An absence of discrimination is not equality.’

There have been several policy documents/reviews, in response to growing awareness about these inequalities (e.g. Department of Health, 2008; NHS National End of Life Care
Programme, 2012; CQC, 2016). However, as Marie Curie, one of the leading palliative care providers in the UK, recently observed,

Despite the wealth of policy documents on access to palliative care for LGBT people, providers of care have been slow to make changes that would make their services more accessible for LGBT people and their families. (Marie Curie, 2016, 13)

Religious-based care

Some of older LGB people’s fears and concerns about older age care relate to religious organisations and/or care workers with strictly held religious beliefs opposed to LGB lives and lifestyles (Westwood and Knocker 2016; Grigorovich 2015).

There is a severe lack of understanding about the particular needs of older lesbian and gay people, especially from some faith-based organisations that provide care services. John, 57, London, UK (Guasp 2011:22)

I think a lot of the care homes are run by faith institutions of some sort who could be very homophobic indeed. (Tim, age 52, UK) (Westwood, 2016c: 19)

To send a religious fundamentalist care worker to visit a gay man is like sending a member of the BNP\(^2\) to a black person. (Spike, older gay man, UK) (Knocker 2013: 10)

Not all religious staff are opposed to LGB lives, and indeed many older LGB people are religious themselves. However, the possibility of religious proselytising may be of particular concern to those cohorts of older LGB individuals who have lived the majority of their lives under the shadow of religious-based discrimination (River and Ward, 2012). In a recent study of care home staff in Wales, Willis et al (2017) reported,

High levels of religiosity, or the degree to which social work students and practitioners invest in religious doctrine, is correlated with less supportive attitudes towards lesbian and gay men’s lives (Willis et al, 2017, 410)

Hafford-Letchfield et al (2018) have also identified

[the] persistence of ingrained homophobia and partial tolerance of LGBT individuals in a setting where care is provided for vulnerable, older individuals. Such anxieties were animated by tensions between religious beliefs and sexuality, which constrained some staff members’ awareness of LGBT lives” (e316)

The ageing population, and an under-resourced care workforce, mean that there is increasing reliance upon care workers from migrant cultures (MacGregor 2007; Walsh and Shutes 2012), some of whom may have faith-based objections to non-heterosexuality. As Hafford-Letchfield et al (2018), reporting on a recent UK project have observed,

It is unsurprising that staff from societies where sexual and gender difference are outlawed and/or attract severe moral condemnation should express hostility or unease but we believe, in principle and in the interests of good practice, that such attitudes require challenge (Hafford-Letchfield et al, 2018, e316)

The tensions between religion and sexual orientation rights ‘is ‘an “uncomfortable” subject which is often ignored in analyses of social care diversity policies’ (Carr 2008: 113), which is
Stakeholders recognised the complexity of balancing conservative religious views of staff and residents (in which same-sex relationships may be regarded as immoral and socially degenerate) with the rights of LGB residents to express and discuss their sexual identity and relationships. One stakeholder described this tension as a ‘liberal nightmare’, framed as an insolvable problem for care staff to have to manage on a day-to-day basis with little practice guidance available. (Willis et al, 2017, 419)

At the same time, older LGB service users have increasing expectations of openness and equality (Cronin et al 2011). They want positive proactive care which is ‘culturally competent’ and validates their lives, identities, relationships and behaviours. Many authors propose that training is the way forward:

Through training, participating staff can be invited to reflect on their beliefs, and to develop practical strategies for addressing religious-based conflicts that may arise across staff–resident and resident–resident interactions. (Willis et al, 2017, 421)

However, training cannot overcome religious beliefs which oppose LGB lives and lifestyles, some of which can be deeply ingrained (Westwood and Knocker 2016). In particular, “‘Negative beliefs of staff from other nationalities in which homosexuality are illegal or persecuted can be deeply entrenched’” (Hafford-Letchfield et al, 2018, e316). Trainers delivering LGBT awareness training to older age care providers in the UK have reported the following concerns:

One staff member declared…that they “knew how to deal with that disease” (Hafford-Letchfield et al, 2018, e316)

‘One staff member stated she would ban her son from the house if he came out as gay (Hafford-Letchfield et al, 2018, e316)

One woman said that if her daughter was lesbian she’d have to “exorcize the demon out of her” and another man just starting from the point of “where does this perversion come from?” on the training and then wanting to go into the whole spiel about how the male and female anatomy are meant for each other. (Joy, UK Activist)

Westwood (2016c: 19-20)

At the back of the room there was somebody who was praying all the time . . . and I’ve heard that from other trainers as well, people praying throughout the training, some even having to be removed because of it. (Jan, UK Activist) Westwood (2016c: 19-20)

It can be hard . . . you know one guy came in and said “what causes this perversion,” and I’ve been prayed over, and there’s been this uprising in the room with people saying “oh if my daughter was . . .” and all this gay conversion stuff, and it’s been pretty, pretty tough, yeah. But interestingly . . . you’ve got to hear the hatred, actually, and sort of expose it, rather than it just staying as subtext. (Sarah, UK activist/ trainer) Westwood (2016c: 19-20)
Matters are further complicated when entire organisations are founded on a religious belief.

Religious organizations may find it more difficult to address sexual issues as the organization’s values in relation to sexual conduct may conflict with those of the residents, particularly in relation to alternative sexualities (Bauer, McAuliffe & Nay, 2007, 67)

This is particularly pertinent given the increasing out-sourcing of care by local government to religious care organisations, bringing the conflict of rights between religion and sexual orientation into welfare spaces (Green, Barton and Johns 2013). Religious-based organisations often provide government-funded care for older people in the UK. For example, the Order of St John Care Trust, a Catholic care organisation, is a major supplier of local authority-funded residential care provision for older people, and the second largest not-for-profit organisation in the UK.\(^3\)

Relationship recognition

In health and social care contexts, non-normative relationships are often under-recognised/ignored and or given fewer rights and privileges than other more normative ones. This particularly affects (older) LGB carers (who are often also caring for older LGB people). As Conaghan and Grabham (2007, 20) have observed,

Rights for carers require an intelligible model of the family that has no space for non-standard intimacies: polyamory, non-standard parental relationships, independent financial arrangements between partners, and close ties between friends.

The under-recognition of LGB carers can mean that they ‘may face exclusion from the statutory measures of support put in place by the Care Act 2014’ (Peel, Taylor and Harding, 2016, 30). This in turn can mean that they do not receive the same levels and quality of support as non-LGB carers, which is to the detriment of both their well-being, and the well-being of the person they are supporting (Westwood, 2018).

In hospitals and hospices, nurses often have to navigate competing rights tensions between biological family and other significant persons, in terms of ‘Next of Kin’ status when an older LGB hospital patient is incapacitated (as in a medical emergency, when they are unconscious, for example: see RCN, 2016). Although under the Mental Capacity Act 2007, Powers of Attorney can establish clear legal rights, not all older LGB people have them (often due to the expense). In addition, the ‘assisted decision-making’ and ‘Best Interests’ decision-making for someone with limited/lacking mental capacity under the Act, can only be put properly into place if the wishes and feeling of the person are understood. If health and social care staff do not understand older LGB people, then it is difficult to see how they can put themselves in their shoes in order to ensure that their best interests are met (Peel, Taylor and Harding, 2016).

In England and Wales, under the Mental Health Act (MHA) 1999, non-partners and non-biological family are privileged in recognition as the ‘Nearest Relative’. Under s. 26(7) MHA, only an individual, other than a relative, who has been living with the person concerned for more than five years, will be considered as Nearest Relative, and then only after biological family members have been excluded. By contrast, in Scotland, however,
under the Mental Health (Care and Treatment) (Scotland) Act 2003, individuals over 16 can nominate a friend as their ‘Named Person’ to support them and protect his/ her interests. If no one is chosen, then the person identified as the ‘primary carer’ will be the ‘Named Person’. This can be anyone, ‘friend’, spouse/partner, or relative, as long as it is the person who provides the majority of informal (i.e. unpaid) care and support. These differing approaches between the two nations highlight how healthcare law can (perhaps inadvertently) either include or exclude LGB significant relationships, thereby empowering/disempowering them in turn.

Equality and human rights

Many healthcare providers employ an equal treatment model of equality. Indeed, in the UK, the NHS Constitution for England (NHS England, 2015) is based on such a model:

[To patients] You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. (6)

[To staff] You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation. (14)

The General Medical Council (GMC, 2012) in the UK also takes a discrimination-avoidant, rather than positive, proactive identity-recognition approach:

We tell our doctors:

‘You must not unfairly discriminate against [patients] by allowing your personal views…about sexual orientation… to affect adversely your professional relationship with them or the treatment you provide or arrange.’

‘…You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.’

The Nursing and Midwifery Council also informs staff that:

‘You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.’ (RCN, 2016, 4)

However, this falls far short of a ‘cultural competency’ approach, which would require healthcare professions to positively and proactively respond to the specific histories, identities, lifestyles and significant relationships of LGB individuals (Westwood et al, 2015). This would include, for example, understanding the historical pathologisation and negative treatment experiences of older LGB people which in turn inform their wariness of healthcare providers.

An over-reliance on equal treatment - i.e. a ‘we treat them all the same’ (Simpson, Almack and Walthery, 2016) approach - can fail to recognise, and appropriately respond to, identity/lifestyle/cultural issues and associated differences in needs. When, in 2017, NHS England (2017) issued clear guidance that ‘sexual orientation’ should be routinely monitored by healthcare providers, there was resistance among certain quarters. In a piece published in
the British Medical Journal this year, Richard Ma and Michael Dixon debated the pros and cons. Dixon argued that requiring doctors to monitor patients’ sexual orientation ‘is political correctness gone mad’ (Ma and Dixon, 2018, k52). Ma, on the other hand, asserted that equality is not about treating everyone the same, but about responding to, and respecting, diversity:

Some think that treating everyone equally should be good enough. But equal treatment is not fair treatment. You would not offer vulnerable patients equal access to care like other patients - you make a special effort because of the special need. Neither can you say that you offer equitable care to LGBT patients without knowing who they are - unless you count them. (Ma and Dixon, 2018, k52)

While the schism demonstrated in the two authors’ debate reflects the wider debate among medical and healthcare professionals, in some quarters medical professionals were unequivocal in their position. According to BBC News (2017):

… the Family Doctor Association said it was "potentially intrusive and offensive" for GPs to monitor people's sexuality. Chairman Dr Peter Swinyard told the BBC that for older patients in particular, sexuality "doesn't affect health outcomes or care"… He added: "Given the precious short amount of time a GP has with a patient, sexuality is not relevant."

In addition to failing to acknowledge the significance of diverse social locations for health and healthcare, an equal treatment approach can also fail to address inequalities of opportunities and outcomes, including those related to older LGB people. Marginalised and disadvantaged groups may face greater barriers to accessing healthcare compared with majority groups, and so may need additional interventions in order to enjoy equality of access. They may also experience poorer health than majority groups and so may need extra support from healthcare provision in order to meet their greater needs and experience equal outcomes. In other words, as Ma has argued, sometimes people need to be treated differently to achieve healthcare equality. It is this need to proactively respond to diversity, in the context of this chapter, age diversity among LGB people, and sexuality diversity (including among older people), that is often missing from currently healthcare provision for older LGB people.

There is also considerable potential to explore the implications of older LGB health and healthcare inequality for current health and social care legislation, and for how equality is formulated in the Equality Act 2010 particularly in terms of its singular approach and the harassment exclusions. In addition, these inequalities may also contravene human rights (Ward, Pugh and Price, 2011). In the UK, the Human Rights Act 1998 (HRA) makes it unlawful for a public authority to act in a way that is incompatible with a person’s rights under the European Convention on Human Rights 1957. Although the thresholds for a breach of rights are high, it is possible that issues of poor healthcare, particularly that which does not respect identities, lifestyles and relationships, might engage any/all of the following Articles: Article 8 (Respect for private and family life, home and correspondence); Article 9 (Freedom of thought, belief and religion); Article 10 (Freedom of expression); Article 11 (Freedom of assembly and association). If any of the rights are breached, then Article 14 (Protection from
discrimination in respect of these rights and freedoms), would also be engaged. Socio-legal scholars thus have much to contribute in addressing these areas.

**Healthcare consultation and research**

Older LGB people are under-represented in healthcare research in three main ways (Westwood, 2016a): in health research which often does not include older people (LGB and non-LGB); in ageing research which often does not include LGB people; and in LGB research which often does not include older people. Sub-populations of older LGB people – lesbians and bisexual women in particular - are even further under-represented in older LGB research which tends to focus on sexuality, rather than gender and sexuality, and in which the voices of older gay men are overly represented (Westwood, 2013a, 2015, 2016a). This lack of inclusion is mirrored in informal healthcare consultation processes and both mean that the voices of older LGB people often go unheard.

**Healthcare advocacy**

Other than a few small specialist projects there is virtually no specialist advocacy with/on behalf of older LGB people, either among LGB advocacy or ageing advocacy services. There is even less healthcare advocacy for older LGB people. In terms of advocacy by healthcare staff on behalf of LGB patients, Somerville’s *Unhealthy Attitudes* report stated (2015, 3),

> There is a lack of confidence among health and social care staff, including those most relevant health and social care practitioners with direct responsibility for patient care, in their ability to understand and meet the needs of LGBT patients and service users.

- Almost six in ten (57 per cent) health and social care practitioners with direct responsibilities for patient care, such as social workers, nurses and mental health workers, say they don't consider sexual orientation to be relevant to one’s health needs.
- One in ten (ten per cent) say they are not confident in their ability to understand and meet the specific needs of lesbian, gay or bisexual patients and service users.
- A quarter (24 per cent) are not confident in their ability to respond to the specific care needs of trans patients and service users.
- One in ten (ten per cent) have witnessed staff within their workplace expressing the belief that someone can be ‘cured’ of being lesbian, gay or bisexual.

In terms of being afraid to speak up, according to Somerville (2015, 4),

> Many health and social care staff say they don’t feel able to challenge discriminatory language and behaviour from their colleagues or patients.

- One in six (16 per cent) patient-facing staff say they would not feel confident challenging colleagues who make negative remarks about lesbian, gay or bisexual people or use discriminatory language such as ‘poof’ and ‘dyke’ towards patients or service users.
- One in six (16 per cent) would not feel confident challenging such remarks from patients.

In terms of staff being ill-equipped to challenge prejudice, Somerville (2015, 7) reported that
A quarter (25 per cent) of staff have never received any equality and diversity training, and those who have often report that the training did not include important issues in caring for LGBT patients and service users.

Almost three in four (72 per cent) patient-facing staff have not received any training on the health needs of LGBT people, the rights of same-sex partners and parents or the use of language and practices that are inclusive of the LGBT community...

It is clear, then, that in terms of health advocacy, LGB people in general, and older LGB people in particular, are not well-represented.

In a review of good practice guidelines in the UK and internationally, Westwood et al (2015, 147-8) identified the following key policy/practice areas which the literature indicates should be addressed in order to improve health equity for older LGBT people:

1. Inclusive consultation in service design and delivery;
2. Appropriate equality and diversity and LGBT-specific policies;
3. Creating a safe working and living environment for staff and service users;
4. A robust staff training strategy;
5. Appropriate language and cultural representation;
6. Person-centred assessment and care planning;
7. Setting and auditing standards.

It is vital that all LGB people, but especially older LGB people (who are more likely to need healthcare provision) receive care that is non-discriminatory and also more than non-discriminatory. They need, deserve and are entitled to care which is positive, proactive and produces equality of outcomes in terms of the best possible person-centred care, not just care which is ‘good enough’ or not good enough at all.

Statute

Care Act 2014
Equality Act 2010
European Convention on Human Rights 1957
Human Rights Act 1998
Mental Capacity Act 2007
Mental Health Act 1999
Mental Health (Care and Treatment) (Scotland) Act 2003

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2 The British National Party (BNP) is a far-right political party in the UK.

3 https://www.osjct.co.uk/where-we-care/care-homes/

5 Opening Doors London (http://openingdoorslondon.org.uk/); SAGE USA (https://www.sageusa.org/)