Government
Equalities Office

National LGBT Survey 2017: Healthcare amongst lesbian and bisexual women

Research report

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Executive summary

Unless otherwise stated, findings relate to cisgender lesbian and bisexual women who responded to the survey. The following findings are all based on statistical models which control for socio-demographics such as age, education level, income, and region.

Disclosing sexual orientation

- Women respondents who were least likely to disclose their sexual orientation to healthcare providers were bisexual, older (aged 55+), single, with low-incomes, lower levels of education, and were living outside London.
- Lesbian women were over three times more likely (312%) to disclose their sexual orientation to healthcare providers than bisexual women.
- Amongst lesbian and bisexual women, younger (aged 16-24) and older (aged 55+) respondents were less likely to disclose their sexual orientation to a healthcare provider than women between the ages of 25 and 54 (27% less likely and 43% less likely respectively).
- Lesbian and bisexual trans women aged 55+ were 39% less likely to disclose their sexual orientation to healthcare providers than those aged 25 to 54.

Accessing and using healthcare services

Mental health services

- Women who were bisexual, younger (aged 16-24), in Wales or Northern Ireland had a harder time accessing mental health services.
- Bisexual women had less positive experiences of mental health services than lesbian women.
- Age was an important factor; younger (aged 16-24) and older (aged 55+) lesbian and bisexual women who accessed or tried to access mental health services found these services more difficult to access than those aged 25-54.
- Amongst both cisgender and trans women who had accessed or tried to access mental health services, regardless of whether they were lesbian or bisexual, the most often cited barriers were that the wait was too long, or that they were worried, anxious, or embarrassed about seeking services.

Sexual health services

- Bisexual women who accessed or attempted to access sexual health services were twice as likely to report that they were unsuccessful compared to lesbian women.
- Amongst trans women, bisexual women reported that it was easier to access sexual health services than lesbian women.
- There were regional variations in using sexual health services: for example, women in Northern Ireland found it both more difficult to access sexual health services and were less positive about the services compared to those in London.

Gender identity services

- Bisexual trans women who were from ethnic minority backgrounds reported that it was easier to access services compared to those who were white.
- Amongst lesbian and bisexual trans women, regardless of whether they tried to access gender identity services, there was the perception that gender identity services were not very easy to access.

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1 Introduction

The Government Equalities Office launched the National LGBT Survey in July 2017 to gain better insight into the experiences of lesbian, gay, bisexual and transgender people and people who identify as having any minority sexual orientation or gender identity, or as intersex, and were aged 16 or more and living in the UK. In total, there were 108,100 valid responses to the survey.

This report is one of a series of short thematic reports, which present further analysis of the survey. It builds on the findings of the main research report[1]. This report presents key findings on **healthcare amongst lesbian and bisexual women** who responded to the survey. The analysis of cisgender and trans women are presented separately as the main survey revealed that the two groups report different experiences.

1.1 Policy context

In May 2018 Public Health England published a report: 'Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women', which identified a significant gap in the evidence base on the health of lesbian and bisexual women. [2]

When the findings of the National LGBT Survey were published, Government also published the LGBT Action Plan.[3] The Action Plan included a commitment to undertake further work to improve understanding of the needs of specific groups within the LGBT population, using the survey data to look into the experiences of different LGBT groups.

Government wants to ensure that LGBT people's needs are at met by the National Health Service, to easily access healthcare when they need it most, and feel comfortable disclosing their sexual orientation or gender identity so that they get the best possible care. By providing this more detailed analysis of the National LGBT survey data, our intention is to add to the evidence base on the health needs of lesbian and bisexual women to help ensure more appropriate healthcare.

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[1] Government Equalities Office (2018) National LGBT Survey - Research Report. Available at: https://www.gov.uk/government/publications/national-lgbt-survey-summary-report

[2] Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women.

[3] Government Equalities Office (2018) LGBT Action Plan. Available at: https://www.gov.uk/government/publications/lgbt-action-plan-2018-improving-the-lives-of-lesbian-gay-bisexual-and-transgender-people

1.2 About this report

For the purposes of this report,

- 'Women' has been used to refer to all respondents who self-identified as 'Woman/Girl' and indicated that they were assigned female at birth;
- 'Trans women' is used when the findings relate to respondents who self-identified as 'Trans women/Trans girl', or who self-identified as 'Woman/Girl' but indicated that they were assigned male at birth.
- 'Cisgender' refers to a person whose gender identity matches the sex they were assigned at birth.
- As the National LGBT Survey is a self-selected (non-random) sample, it may not be representative of the LGBT population in the UK. The results may only be generalised to this sample only.
- All results presented in this report take into account (control for) a range of socio-demographic characteristics including age group, educational qualifications, relationship status, income, region, religion, and disability status.

Unless otherwise stated, all findings relate to cisgender lesbian and bisexual women who responded to the survey.

1.3 Method

Given the stated limitations of the National LGBT Survey (see Section on Limitations at the end of this report), this research is intended to examine differences and associations among sub-groups of respondents. It is not to calculate estimates of prevalence for the LGBT population in the UK. The survey respondents were self-selecting and do not necessarily reflect the UK LGBT population.

Multivariate linear (continuous outcome variables) and logistic (categorical outcome variables) models were estimated to identify differences between two or more groups. All models controlled for several individual characteristics, including age group, educational qualifications, relationship status, income, region, religion and disability status. This allows us to be more confident that differences reported between groups are genuine, and not caused by these other potential factors.

Data presented in this report may not add up to 100% due to exclusion of reporting of small cell sizes and participants being able to choose more than one response option. All 'prefer not to answer' responses were excluded from analysis.

Full tables and statistical model outputs are presented in tables in the **Annex for statistical models**.

1.4 About the sample

This analysis is based on around **38,600 cisgender and trans women respondents** who reported their sexual orientation as lesbian or bisexual in the National LGBT Survey 2017. The sample comprised 36,330 cisgender women, of whom 20,400 identified as lesbian and 18,200 as bisexual, and 2,280 trans women.

Amongst **cisgender women** respondents, 46% reported their sexual orientation as bisexual and 54% as lesbian. Bisexual women were more likely to be young (age 16-24 65%) while lesbian women were slightly older (age 25-54 59%). Bisexual respondents were most commonly single (45%), although about a quarter of them were engaged in dating relationships (26%). In contrast, 48% of lesbian women were married, in a civil partnership, or living with a partner. Bisexual respondents reported lower incomes, with 61% earning less than £20,000 per annum, compared to 44% of lesbian respondents. Lesbian respondents' reported higher levels of education, with 53% having a bachelor's degree or higher compared to 44% of bisexual women. Slightly more bisexual women reported having a disability (19%) than lesbian women (14%). About equal numbers of lesbian and bisexual women lived in the different areas of the UK, and there were no differences between lesbian and bisexual women by ethnic group or religion in general [see Table 1 in Annex].

Amongst **trans women** in the sample, 59% reported their sexual orientation as bisexual, and 41% as lesbian. Slightly more lesbian women reported having a disability (29%) than bisexual women (24%). About equal numbers of lesbian and bisexual women lived in the different areas of the UK, and there were no differences between lesbian and bisexual women in their age distribution, relationship status, region of residence in the UK, ethnic group, or religion [see Table 2 in Annex].

2 Disclosing sexual orientation to healthcare providers

2.1 Which groups disclose their sexual orientation in general healthcare settings?

Amongst cisgender respondents, after controlling for a wide range of socio-demographic characteristics, such as ethnic group, age, and education, whether women were lesbian or bisexual was a key predictor of whether they disclosed sexual orientation to healthcare providers or not. When accessing healthcare, **lesbian women were over three times more likely to disclose their sexual orientation to staff as bisexual women (312%)**.

Age was a predictor of whether women disclosed their sexual orientation to healthcare providers: **among lesbian and bisexual women, younger (aged 16-24) and older (aged 55+) respondents were less likely to disclose their sexual orientation to a healthcare**

provider than women between the ages of 25 and 54 (27% less likely and 43% less likely respectively).

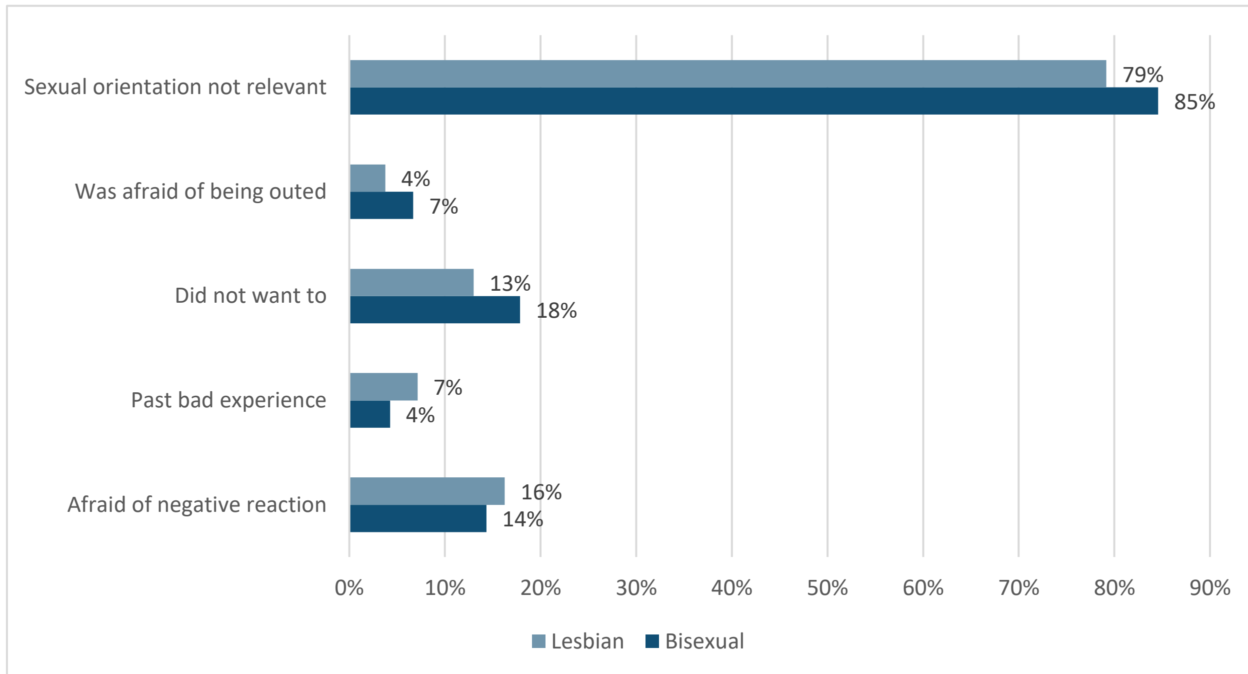
Women who were least likely to disclose their sexual orientation to healthcare providers were also:

- single;
- low-income;
- had lower levels of education;
- were disabled; and,
- lived outside London.

Women's ethnic group *did not* affect whether respondents disclosed whether they were lesbian or bisexual [See Table 4 in Annex for statistical models].

Women who accessed services reported a variety of reasons for not disclosing their sexual orientation, but by far the most commonly cited reason was that they did not feel their sexual orientation was relevant to their healthcare. Bisexual women were more likely to cite this reason than lesbian women (85% and 79% respectively). The next most common reason bisexual women gave for not disclosing their sexual orientation was that they simply did not want to (18% vs. 13% of lesbian women), while for lesbian women it was that they were afraid of a negative reaction (16% vs 14% of bisexual women). The reasons women gave are presented in Figure 1.

Figure 1: Cisgender lesbian and bisexual women's reasons for non-disclosure of sexual orientation in general healthcare settings, National LGT Survey 2017



Base (rounded): 26,830
Respondents: Cisgender Lesbian and Bisexual Women
Note: This question allowed multiple response options, therefore totals may add to more than 100%

For trans women, equal proportions (67%) of lesbian and bisexual women reported disclosing their sexual orientation to healthcare providers.

After controlling for socio-demographic characteristics, age was a predictor of disclosure of sexual orientation when accessing healthcare. **Among trans women, older respondents (aged 55+) were 39% less likely than respondents aged 25 to 54 to disclose their sexual orientation**, while those aged 16-24 were just as likely as women aged 25-54 to disclose their sexual orientation. This was true for both lesbian and bisexual respondents.

Region was a predictor of disclosure of sexual orientation to healthcare providers amongst lesbian and bisexual trans women. Compared to respondents in London, those living in the rest of England were 22% less likely to disclose their sexual orientation to healthcare staff, while respondents living in Wales were 29% less likely, those living in Scotland were 29% less likely, and those living in North Ireland were 25% less likely to disclose.

No relationship was found between the disclosure of sexual orientation to a healthcare staff and the sexual orientation, ethnic group, income, or relationship status for lesbian and bisexual trans women [see Tables 8-9 in Annex for statistical models].

2.2 Does disclosing sexual orientation affect experiences of general healthcare?

Amongst cisgender respondents, most women who reported disclosing their sexual orientation to healthcare staff said it had no effect on their care, irrespective of whether they were bisexual (79%) or lesbian (78%). Among those who said it did have an impact on their care 52% reported that the effect was more positive than negative.

Accounting for socio-demographic characteristics, certain groups were especially likely to report that disclosing their sexual orientation had affected their healthcare in a positive or negative way. Amongst those who did disclose their sexual orientation, lesbian women were 23% more likely to report an effect (either positive or negative) when compared to bisexual women. Age was a factor in who reported that the effects of disclosure on their healthcare were positive, with younger women (aged 16-24) 25% more likely to report a positive effect of disclosure than women aged 25-54. Disabled women were 39% less likely to say that the effect of disclosure was positive when compared to non-disabled women.

Respondents with higher levels of education were less likely to report that disclosing their sexual orientation had a positive effect on their healthcare. Compared to those with a secondary education, those with post-secondary education (i.e. college, A-level, undergraduate and post-graduate degrees, and vocational qualifications) were 35% less likely to report a positive effect.

Amongst those who reported disclosing sexual orientation, after accounting for socio-demographic characteristics, region also had an effect on perceived experience of healthcare: respondents in Scotland were 1.4 times more likely to report a positive effect resulting from disclosure, when compared to those in London [see Tables 5-6 in Annex for statistical models].

Amongst trans women, those who were bisexual were equally likely as those who were lesbian to report that disclosure of their sexual orientation had a positive effect on their healthcare.

Region was a predictor of disclosure of sexual orientation to healthcare providers amongst lesbian and bisexual trans women. **There were however no differences in the level of perception about whether disclosure of sexual orientation affects care by region for lesbian and bisexual trans women, with the exception of Wales where they were 82% less likely to report a positive effect of disclosure compared to those in London** [see Table 10 in Annex for statistical models].

3 Experiences accessing and using mental health services

3.1 Who is accessing mental health services?

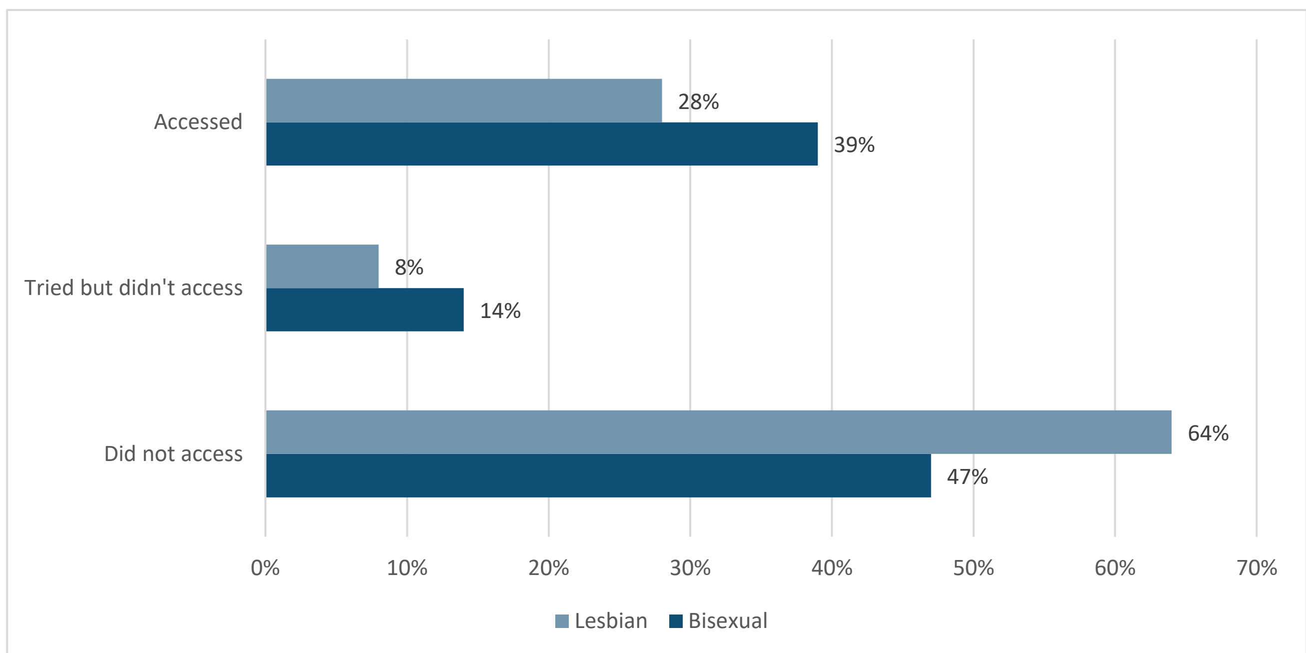
Amongst cisgender respondents, 28% of lesbian and 39% of bisexual women accessed mental health service.

Overall, the following groups were most likely to have accessed mental healthcare services:

- bisexual;
- younger;
- single; and,
- low-income [see Table 11 in Annex for statistical models].

Lesbian women were 17% less likely to have accessed mental health services compared to bisexual women, and **bisexual women were 26% more likely to have tried to access mental health services without success compared to lesbian women** [see Figure 2].

Figure 2: Cisgender women's mental healthcare access status by sexual orientation, National LGBT Survey 2017



Base (rounded) Base (rounded): 29,100
Respondents: Cisgender Lesbian and Bisexual Women

Amongst transgender respondents, lesbian and bisexual women were equally likely to have accessed mental health services.

After accounting for socio-demographic factors, there were differences by age: respondents aged 16-24 were 37% less likely, and those who were 55 or older were 71% less likely to

access mental health services when compared to respondents aged 25 to 54. Lesbian and bisexual trans women who were disabled were 82% more likely to access mental health services than those were not disabled.

Amongst lesbian and bisexual trans women who attempted to access services there were no differences between those who were successful and those who were not, by sexual orientation or by any other socio-demographic characteristics [see Tables 22-23 in Annex for statistical models].

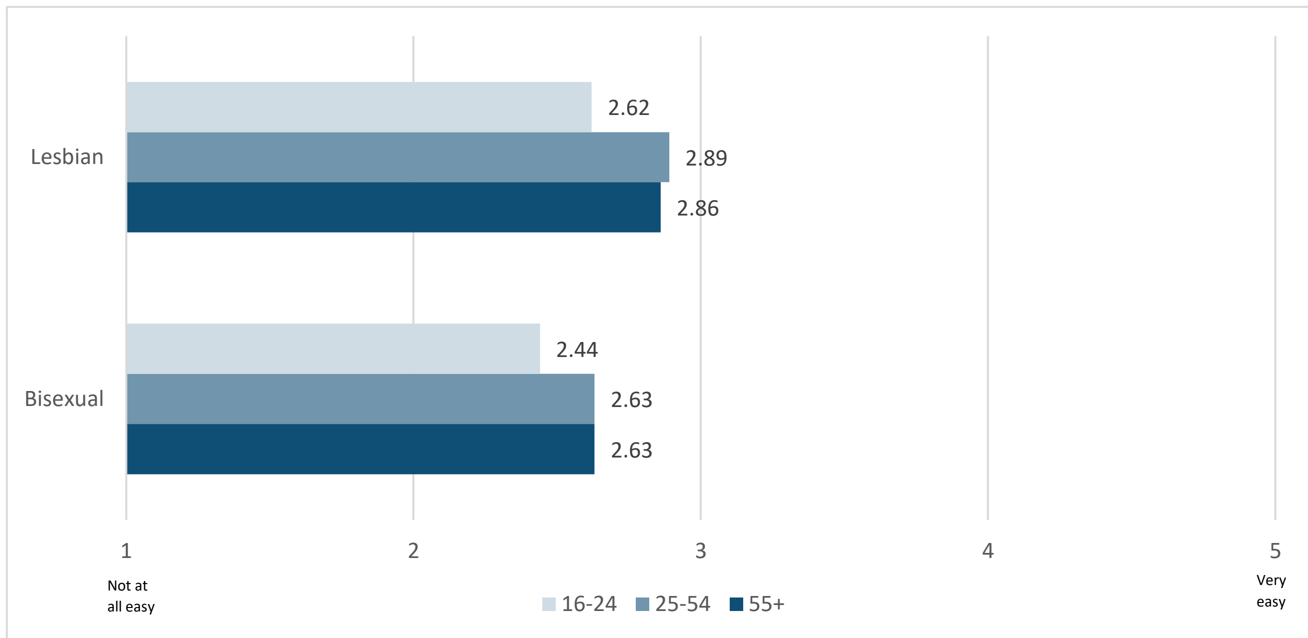
It is important to note that these results reflect that there were certain groups of respondents using services more than others, however, there may be other factors not captured by the survey and are not reported here which impact use.

3.2 How easy is it to access mental health services?

Amongst cisgender respondents who accessed or attempted to access mental health services, lesbian and bisexual women differed in their perceptions of how easy it was to access services. After accounting for socio-demographic characteristics, **lesbian women reported that it was easier to access mental health services than bisexual women** [see Table 20 in Annex for statistical models]. Amongst those who tried to access services but were unsuccessful, there was no difference between lesbian women and bisexual women in their perceptions of how easy services were to access [see Table 12 in Annex for statistical models].

Across all age groups, lesbian women reported that it was easier to access mental health services than bisexual women [see Figure 3 and see Table 20 in Annex for statistical models].

Figure 3: Mean rating for how easy mental health services were to access among cisgender women by sexual orientation and age, National LGBT Survey 2017

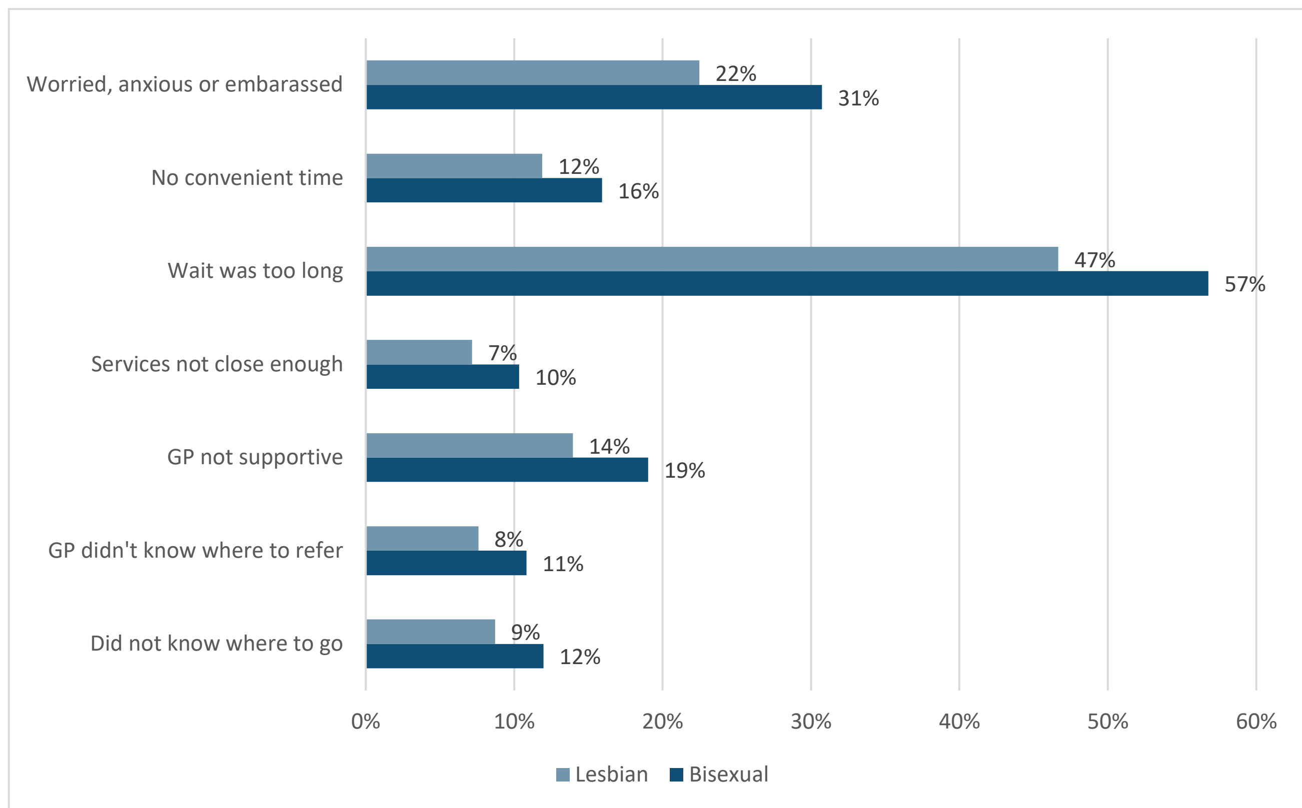


Base (rounded): 12770
Respondents: Cisgender lesbian and bisexual women who accessed or tried to access mental healthcare services.

Amongst women who successfully accessed mental health services, and after accounting for socio-demographic characteristics, **lesbian women were more positive about their experiences of mental health services than were bisexual women,** rating their experience 0.07 points higher than bisexual women [see Table 21 in Annex for statistical models].

Amongst lesbian and bisexual women, the most often cited barriers to accessing mental health services were that the wait was too long, or that they were worried, anxious, or embarrassed about seeking services [see Figure 4, and Tables 13-19 in Annex for statistical models].

Figure 4: Barriers to accessing mental healthcare services among cisgender lesbian and bisexual women, National LGBT Survey 2017



Base (rounded): 12,570
Respondents: Cisgender lesbian and bisexual women who accessed or tried to access mental healthcare services.

Amongst trans women, by far the most commonly cited reason for not accessing services, regardless of sexual orientation, was that the wait for services was too long. The next most common reason was that they were worried, anxious or embarrassed about seeking services [see Tables 24-30 in Annex for statistical models].

4 Experiences of accessing and using sexual health services

4.1 Who is accessing sexual health services?

Most cisgender women respondents (75%) reported that they had not accessed sexual health services over the 12-month period preceding the survey, while 13% of lesbian and 38% of bisexual women had accessed these services.

Amongst those who did successfully access services there were some differences by sexual orientation and ethnic group. Lesbian women, for example, were 70% less likely to access services than bisexual women. Ethnic minority lesbian women were more likely to access sexual health services than ethnic minority bisexual women [see Table 33 in Annex for statistical models]. **Bisexual women who accessed or attempted to access sexual**

health services were twice as likely to report that they were unsuccessful compared to lesbian women [see Table 34 in Annex for statistical models].

Amongst trans women, 13% of bisexual and 9% of lesbian women accessed sexual health services in the 12-months preceding the survey. Twenty-three per cent of lesbian and bisexual trans women in London accessed sexual health services compared to 10% in the rest of England, 14% in Scotland, 16% in Wales and 13% in Northern Ireland.

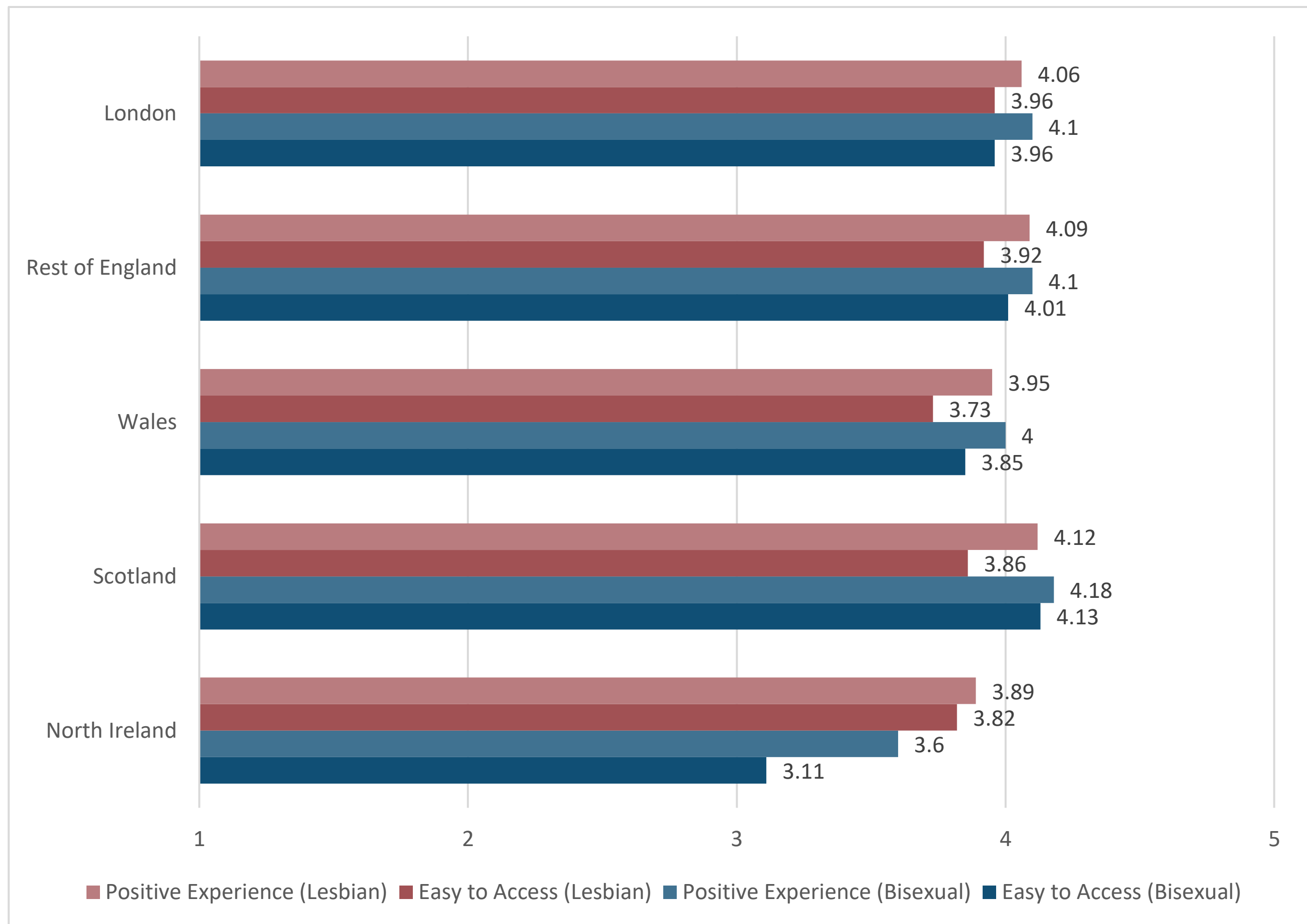
Trans women who were lesbian were 34% less likely than those who were bisexual to access sexual health services. Region also mattered, with those living in the rest of England 66% less likely, and those living in Scotland 48% less likely to successfully access sexual health services than those living in London [see Table 44 in Annex for statistical models].

4.2 How easy it is to access sexual health services?

Cisgender women who reported accessing sexual health services in the 12-months preceding the survey were asked to rate how easy the services were to access. After accounting for socio-demographic characteristics, there was no difference in perceptions of how easy it was to access services for lesbian and bisexual women. Region did matter for perceptions of how easy services were to access with respondents living in Wales rating ease of access to services 0.15 points lower than those living in London [see Table 42 in Annex for statistical models]. **Women from Northern Ireland reported that it was both more difficult to access sexual health services (0.60 points lower) and their experiences with services were less positive (0.38 points lower) compared to respondents in London** (see Figure 5).

There was no difference in how positive respondents reported their experiences to be for lesbian and bisexual women [see Table 43 in Annex for statistical models].

Figure 5: Mean rating for how easy sexual health services were to access and how positive women's experiences with services were among cisgender lesbian and bisexual women by region, National LGBT Survey 2017



Base (rounded): 7,680

Respondents: Cisgender lesbian and bisexual women who successfully accessed sexual health services in the 12 months preceding the survey.

Note: 1=not positive or not easy to access, 5=very positive or very easy to access.

Amongst trans women, sexual orientation was a predictor of how easy respondents felt it was to access services, with bisexual women reporting that it was easier to access sexual health services than lesbian women [see Table 51 in Annex for statistical models]. There were no differences in how positive lesbian and bisexual trans women felt their experience of sexual healthcare were by any socio-demographic factors, such as age, ethnicity, region or income [see Table 52 in Annex for statistical models].

5 Transgender respondents' experiences of accessing and using gender identity services

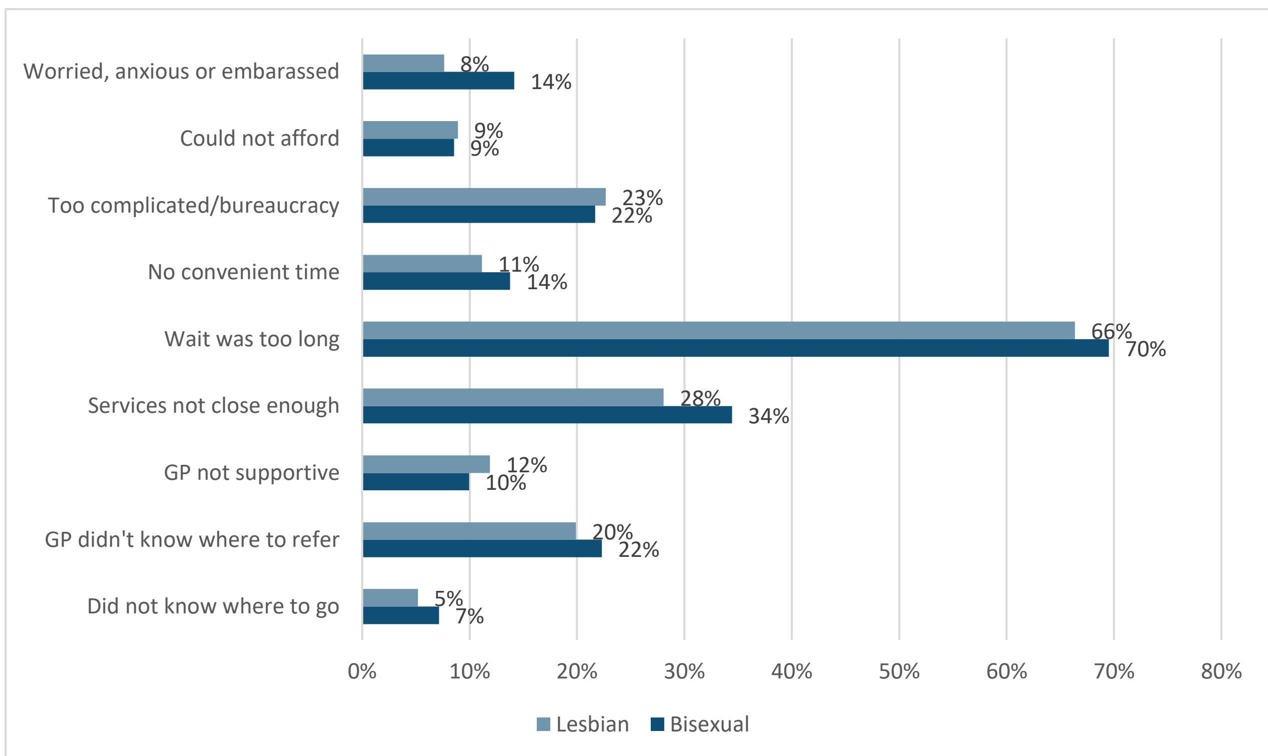
Amongst lesbian and bisexual trans women, regardless of whether they tried to access gender identity services, there was the perception that gender identity services were not very easy to access. Overall, half of all respondents, both lesbian

(50%) and bisexual (50%), reported accessing gender identity services [see Table 52 in Annex for statistical models]. Trans women who were bisexual reported a slightly lower means of ease of access (mean=2.19) compared to those who were lesbian (mean=2.31). Bisexual women felt that it was more difficult to access services than did lesbian women. However, there were differences by ethnic group and sexual orientation.

Bisexual trans women who were from ethnic minority backgrounds reported that it was easier to access services compared to those who were white. Amongst lesbian women, ethnic minority and white women felt that it was equally easy to access services [see Table 63 in Annex for statistical models].

Lesbian and bisexual women who reported successfully accessing gender identity services in the 12-months preceding the survey were equally positive about the gender identity services they received [see Table 64 in Annex for statistical models]. Amongst those who did not access services, by far the most common reason given was that the wait was too long, followed by issues with the services being too far away, and concerns about the complexity of the bureaucracy they needed to navigate in order to receive services (see Figure 6) [see Tables 54-62 in Annex for statistical models].

Figure 6: Reasons for not accessing gender identity services among transgender lesbian and bisexual women, National LGBT Survey 2017



Base (rounded): 1,180
Respondents: Transgender lesbian and bisexual women

6 Conclusion

Overall, most respondents did not access healthcare services of any sort in the 12-months prior to the survey. Among cisgender respondents, bisexual women were more likely to access all types of health services and were also more likely to have tried and failed to access all types of services compared to lesbian women. The most common barrier across all services was prolonged wait times, with worry about disclosing sexual orientation also frequently cited across different types of healthcare settings. While lesbian women accessed healthcare services less frequently, when they did they were more likely to disclose their sexual orientation to their healthcare provider than bisexual women. Lesbian women also found it easier to access mental healthcare services than bisexual women. Lesbian women were also more likely to disclose their sexual orientation in general healthcare settings and this disclosure was more likely to result in positive reactions from healthcare providers overall than it was for bisexual women.

The experiences of younger women (aged 16-24) and older women (aged 55+) were somewhat different across healthcare settings when compared to women aged 25-54. Younger and older women were less likely to disclose their sexual orientation, although younger women (aged 16-24) experienced more positive responses when they did disclose. Younger women (aged 16-24) were also more likely to access mental healthcare when compared to women aged 25-54, suggesting a higher demand for mental health services among young lesbian and bisexual cisgender and trans women, however younger women also felt that accessing those services was more difficult than women aged 25-54.

When it came to sexual health, region made the most difference in care received. Compared to women in London, for example, those in Wales reported having more difficulty in accessing sexual health services, while women in Northern Ireland cited both difficulty with access and less positive experiences when they did access sexual health services.

While some women had difficulty accessing multiple types of services, it was more common for respondents to report difficulty accessing only one type of service. In some cases, this was because they only attempted to access one type of service, and in other cases this was because respondents reported fewer barriers to attempting to access services or they felt more comfortable with accessing a particular type of service (for example, general healthcare as opposed to sexual healthcare or gender identity services). Overall, the fact that difficulty with accessing services was not specific to one group of women with specific socio-demographic characteristics, suggests that problems with healthcare access among lesbian and bisexual cisgender and trans women is a complex problem, with a wide variety of underlying reasons together accounting for any difficulty women may have in accessing and using a wide variety of healthcare services in the UK.

7 Limitations of this research

Some of the limitations associated with this report are that the sample is self-selected, all responses are self-reported and may thus be subject to bias or error. For example, respondents self-reported their sexual orientation; however other measures of sexual identity, i.e. sexual behaviour or attraction were not included. The survey was conducted online which means that non-respondents may differ from respondents in a variety of characteristics, i.e. resources to access the internet, access to own device if not open, etc. The survey was also cross-sectional, i.e. taken at one point in time, and therefore we cannot make any claims about the direction of associations or causation.

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