International Journal for Equity in Health

RESEARCH

Open Access

# The inclusion of LGBTQ + people within UK health policy: a critical discourse analysis

Debbie Braybrook[1], William E. Rosa[2], Charlotte Norman[1], Richard Harding[1] and Katherine Bristowe[1*]

## Abstract

**Background** Health policymakers can leverage change to improve equity in access to care, patient experiences and clinical outcomes. Despite legal progress to reduce health inequalities, social and systemic injustices persist and lesbian, gay, bisexual, trans and queer (LGBTQ+) people have increased risk of some health conditions and poorer health outcomes linked to the discrimination they experience. In 2022, 42 regional integrated care systems were created across England to reduce health inequalities and improve the wellbeing of their local population.

**Methods** This study aimed to examine the inclusion of UK Equality Act (2010) protected characteristics within the 42 publicly available integrated care system strategies, and to consider specifically how LGBTQ + communities and their needs, experiences and outcomes are framed within these strategies. A Critical Discourse Analysis was conducted positioned within a social constructivist paradigm.

**Results** Almost all strategies talked about the needs of their populations in terms of age (42/42), disability (42/42), gender (41/42), ethnicity (39/42) and maternity or pregnancy (39/32). 27/42 strategies mentioned religion. There were no references to marital status. 22/42 strategies referred to LGBTQ + people, but only around 25% of those references provided context about the specific needs of LGBTQ + people, the health inequities they face, or services for LGBTQ + people. Regarding gender minorities, there were eight mentions of trans people and no mentions of intersex people, despite some policies using the acronym LGBQTI. While there were two mentions of inequities in care delivery for trans people, the specific health or social care needs of trans people were not described in any strategies, and there were a small number of examples where trans people were presented in a problematizing frame; with no discussion of trans inclusive care, only problems associated with being trans. Across all 42 strategies there were only four references to systemic forces (e.g. homophobia, transphobia, discrimination) affecting LGBTQ + people.

**Conclusions** While the needs of some minoritized groups are well recognized within health policies, LGBTQ + people remain marginalized. Further work is needed to educate and enable policy makers to advocate for LGBTQ + people and communities, and to ensure equitable and respectful inclusion of all minoritised groups.

**Keywords** Minority health, LGBTQIA+, Health policy, Qualitative research

*Correspondence:
Katherine Bristowe
Katherine.bristowe@kcl.ac.uk
[1]Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, King's College London, Bessemer Road, London SE5 9PJ, UK
[2]Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York, NY, USA

## Introduction

The World Health Organization states that health equity 'is achieved when everyone can attain their full potential for health and well-being' [1]. However, the ability to achieve health equity is shaped by geographical, financial, political, and structural determinants. Social and systemic injustices disproportionately impact individuals from minoritized and marginalized groups, and negatively affect their access to, experiences and outcomes of health and social care. LGBTQ + people (lesbian, gay, bisexual, trans and queer people '+' others who consider themselves to have a minoritized sexual orientation or gender identity) have increased risk of certain health conditions including cardiovascular disease and some forms of cancer. The stress they experience through exposure to discrimination and stigma are linked to these adverse outcomes in part due to behavioral responses to the stressors including higher rates of tobacco, alcohol and drug use [2, 3], and increased levels of psychological distress [4]. Health disparities exist across multiple domains, and there is consistent evidence that structural stigma increases the risk of poor health [5].

In the UK initial advances in LGBTQ + rights were seen in 1967 through the Sexual Offences Act [6] which partially decriminalized sexual relations between men. However, during the 1980s alongside the advent of the HIV/AIDs pandemic, and increasing anti-LGBTQ + rhetoric, the then government introduced Sect. 28 under the Local Government Act which prohibited the 'promotion of homosexuality' [7]. In response to this, the campaigning organization Stonewall was formed to lobby against this law. However, it was not until the 2000s that the age of consent was lowered for gay and bisexual men to align with heterosexual couples, Sect. 28 was repealed [8], the Civil Partnership Act [9] and Marriage Act [10] enabled legal recognition of same-sex relationships, and the Gender Recognition Act [11] enabled trans people to legally change their gender. Globally, although some advances in LGBTQ + equality are evident, reports from non-governmental organizations demonstrate that currently 65 countries still criminalize same-sex sexual activity, of which 12 can impose the death penalty, and 14 countries criminalize the gender identity or expression of trans people [12, 13].

The fundamental principle of the UK National Health Service (NHS) is for everyone to be able access care based on need, not ability to pay [14]. The recognition of the inequalities experienced by some groups has led to legislative change. The UK Equality Act (2010) [15] protects individuals from discrimination when accessing goods and services, including health and social care, in relation to nine protected characteristics: age, sex, gender reassignment, sexual orientation, disability, ethnicity, religion, marital status and maternity or pregnancy. The subsequent Health and Social Care Act (2012) [16] made it a legal duty for health and social care services to reduce inequalities in benefits experienced from services for people in England. Despite this almost one quarter of UK LGBTQ + people have witnessed anti-LGBTQ + remarks by healthcare staff, and one in seven had avoided treatment for fear of discrimination, and a similar proportion experienced unequal treatment because they are LGBTQ+ [17]. Experiences and fears of discrimination continue to impact access to healthcare services, resulting in reluctance to access care, and delayed presentation [18].

In 2019, the NHS long term plan stated its aim to improve the integration between health and social care by establishing Integrated Care Systems [19]. Forty-two Integrated Care Systems were established across England in July 2022, and each was tasked with improving the health of their local population and reducing health inequalities. Approaches such as the Core20PLUS5 [20] are central to these efforts, as they enable Integrated Care Systems to prioritize their resources towards the "20%" who are most deprived, "PLUS" those who may be marginalized due to their protected characteristics or social exclusion, across "5" priority clinical areas. Each Integrated Care System was tasked with developing a strategy delineating their priorities. The publication of these strategies represents a unique opportunity to explore how health inequities are prioritized within UK health policy. The aim of this study therefore was to examine the inclusion of UK Equality Act (2010) protected characteristics [15] within NHS Integrated Care System strategies, and to consider specifically how LGBTQ + people and their needs, outcomes and experiences are framed within these strategies.

## Methods

### Research paradigm

This study is positioned within a social constructivist paradigm, which posits that humans are socially situated, and knowledge is constructed in interaction with others. Discourse, whether written or spoken, is a social practice; the language we use shapes society, culture and perspectives, and reciprocally, the society we live in shapes the lexical choices we make [21]. Social constructivism is also well placed to explore issues related to gender, sex and sexual orientation. It is through history, the sociopolitical context, and interactions that meanings are attributed to these identities or characteristics, and it is socially constructed forces of oppression and power that maintain and perpetuate the disadvantages experienced by some groups or communities [22].

## Analysis

### *Identification of strategies*

One author (KB) identified the Integrated Care System strategies (hereafter 'strategies') from their websites in April 2024. Where it was not possible to identify the strategy to download, the Integrated Care System was contacted to provide it.

### *Initial coding and summative analysis*

A coding frame for LGBTQ + communities, developed for a previous documentary analysis [23], was applied to each strategy. This included 28 key search terms related to LGBTQ + identifies, derived from the literature. A second coding frame was developed by KB and DB to identify terms related to the remaining seven protected characteristics under the UK Equality Act (2010). During initial testing of the search terms, there was evidence that terms related to sex and gender were used interchangeably in some strategies. As such, while the Equality Act lists 'sex' but not 'gender' as a protected characteristic, the decision was made to aggregate terms related to sex and gender together to ensure all potential references were included. The second coding frame included 28 key search terms (see Table 1). References to each search term were quantified within each strategy and recorded in an Excel spreadsheet.

### *Critical discourse analysis*

The second phase of the analysis was designed to provide deeper understanding of how the needs, outcomes and experiences of LGBTQ + people are framed within the strategies. Discourse analysis is an umbrella term for methodologies that treat language itself as the data for analysis [24]. These approaches are used to consider how meaning is created within a particular context, setting or genre. Discourse, whether written or spoken, is a social practice; it shapes and is shaped by the society we live in [21]. Critical Discourse Analysis uses discourse analytic techniques to systematically analyze language within documents at multiple levels, and has particular utility when examining issues of power and inequality [24]. This crucial but underused analytical approach exposes how structural inequities are engrained in and perpetuated by policy.

### *Approach*

A Critical Discourse Analysis of these data, adapted from Fairclough's approach [25], was led by KB (a sociolinguist) and refined with co-authors. Each mention of the LGBTQ + search terms was identified, and the full paragraph in which it was mentioned extracted into an Excel spreadsheet. Analysis was then conducted at multiple levels. The micro-level deductive analysis focused specifically on categorizing the words used to describe LGBTQ + people. The meso-level analysis was inductive and zoomed out to examine the text proximately located to each reference. This enabled the authors to consider how the strategies engage with LGBTQ + communities, any patterns in how they are presented, and the framing and broader discourses this draws on (interdiscursivity), including social and/or systemic injustices (e.g. discrimination, homophobia, transphobia). In the final macro-level analysis the authors considered the implications of the findings for the genre (UK health policy) and for practice. As this most closely aligns stylistically with the discussion section in health services research journals, this has been integrated within the discussion.

## Results

### The sample

We identified 41/42 full ICB strategies. For the one remaining strategy, only a summary was available. The Integrated Care System were contacted for a full copy of the strategy, but no response was received. A decision was made to include the summary strategy within the analysis. Strategies were published between December 2022 and March 2024 (6 strategies did not include a publication date). Strategies ranged from 15 to 154 pages

**Table 1** Search terms

| Protected Characteristics | Search terms |
|---|---|
| Sexual orientation / gender reassignment status (gender identity) | Asexual, bisexual, gay, gender identit*, gender minorit*, gender orientat*, homosex*, homophob*, intersex, key population*, lesbian, LGB*, men who have sex with men, MSM, non-binary, non-heterosexual, pansexual, queer, questioning, same-gender, same-sex, sex characteristics, sexual identit*, sexuality, sexual minorit*, sexual orientat*, trans*, transphob* |
| Ethnicity | BAME, BME, ethnic* (ethnicity, ethnically), rac* (race, racial, racist, racism) |
| Disability | Disab* (disability, disabilities, disabled), impair* (impaired, impairment, impairments) |
| Age | Ag* (aged, ages, ageing, aging), old* (older, oldest), young* (younger, youngest) |
| Sex / gender | Sex*, gender*, male*, female*, man/men*, woman/women* |
| Religion | Relig* (religion, religious), faith, belief*, spiritu* |
| Marriage / civil partnership | Marriage, marital, civil partner* |
| Maternity / pregnancy | Matern* (maternity, maternal), pregnan* (pregnancy, pregnancies, pregnant), Pre* (prenatal, pre-natal), peri* (perinatal, peri-natal), post* (postnatal, post-natal, post birth, post-birth postpartum, post-partum), ante* (antenatal, ante-natal) |

with a median length of 41 pages (the summary strategy was 10 pages long).

## Findings

Section one below presents the findings of the summative analysis related to all protected characteristics excluding sexual orientation and gender identity. Sections two and three present the micro- and meso-level Critical Discourse Analysis related to LGBTQ + identities.

### *i. Summative findings for protected characteristics (excluding sexual orientation and gender identity)*

The most frequently referenced protected characteristic was age, with 2163 references across all 42 strategies (see Table 2). Many had sections specifically on aging, and children and young people, and described the needs of particular age groups (e.g. 'people of working age'). The second most frequently included characteristic, referenced in all strategies, was disability (580 references), with most using the term 'disability' and a few referring to cognitive and visual 'impairments'. All but one (97%) of the strategies made reference to sex or gender, although these terms were at times conflated within the strategies (e.g. describing 'Life expectancy by gender' but comparing males and females). There were more references to women and females than men or males (275/166). Ethnicity was recognized within most strategies (39/42, 93%), and Integrated Care Systems tended to favor 'ethnicity', over 'race' or acronyms related to minoritized communities (e.g. 'BME', 'BAME'). Most strategies also recognized the needs of pregnant people (39/42, 93%), with some specific sections on maternity services, and perinatal health and wellbeing. Religion and religiosity were less well recognized within the strategies at just

**Table 2** Summative findings for protected characteristics

| Protected Characteristic | Total count across all strategies | No. of strategies including each characteristic (%) | Search Term | Total count across all strategies |
|---|---|---|---|---|
| Sexual Orientation and Gender Identity | 100 | 22/42 (52%) | Acronyms | 41 |
| | | | Sexual Orientation | 47 |
| | | | Gender Identity | 12 |
| Ethnicity | 397 | 39/42 (93%) | race, racial, racist, racism | 81 |
| | | | Ethnic, ethnicity, ethnically | 291 |
| | | | BME | 4 |
| | | | BAME | 21 |
| Disability | 580 | 42/42 (100%) | Impaired, impairment, impairments | 18 |
| | | | disability, disabilities, disabled | 562 |
| Age | 2163 | 42/42 (100%) | age, aged, ages, aging, ageing | 862 |
| | | | old, older, oldest | 325 |
| | | | young, younger, youngest | 976 |
| Sex / gender | 495 | 41/42 (98%) | Sex, sexes | 22 |
| | | | Gender, genders | 32 |
| | | | Male, males | 99 |
| | | | Female, females | 103 |
| | | | man, men | 67 |
| | | | woman, women | 172 |
| Religion | 109 | 27/42 (64%) | religion, religious | 11 |
| | | | Faith, faiths | 86 |
| | | | Spiritual, spirituality | 2 |
| | | | belief, beliefs | 10 |
| Marriage / Civil partnership | 0 | 0/42 (0%) | marriage | 0 |
| | | | marital | 0 |
| | | | civil partnership | 0 |
| Maternity / pregnancy | 366 | 39/42 (93%) | maternity, maternal | 216 |
| | | | pregnancy, pregnancies, pregnant | 110 |
| | | | Prenatal, pre-natal | 2 |
| | | | Perinatal, peri-natal | 23 |
| | | | postnatal, post-natal, post birth, postpartum, post-partum | 12 |
| | | | Antenatal, ante-natal | 3 |

109 references across 27 (64%) strategies. Integrated Care Systems tended to favor 'faith' and 'beliefs', rather than 'religion' specifically, and this was often in relation to faith based voluntary support services. There was no mention of marriage, marital status or civil partnership within the strategies.

#### *ii. Micro level critical discourse analysis*

One hundred references to LGBTQ + people were identified across 22/42 (52%) strategies (see Table 3). Within 7/22 there was just one reference to LGBTQ + people. The most commonly used (41/100) terms were acronyms (LGBTQ+, LGBT+, LGBTQI, LGBTQI+, LGBT and LGBQTrans), which were rarely explained. Despite four usages of LGBTQ*I* or LGBTQ*I*+, there were no mentions of intersex people. 'Lesbian', 'gay' and 'bisexual' were all used 10 times, and always listed together. Four usages of 'key population' were identified. These were subsequently excluded as they referred to 'key population health risks', describing 'key risks', rather than 'key populations'. Excluding acronyms there were 47 references to sexual orientation and/or minoritized sexual identities across 18 strategies, and 12 references to gender identities across 8 strategies.

**Table 3** Detailed summative findings for sexual orientation and gender identity

| Search Term | Total count across all strategies | No. of strategies including each term (%) |
|---|---|---|
| asexual | 0 | 0 (0%) |
| bisexual | 10 | 7 (17%) |
| gay | 10 | 7 (17%) |
| gender identit* | 2 | 2 (5%) |
| gender minorit* | 0 | 0 (0%) |
| gender orientat* | 0 | 0 (0%) |
| homosex* | 0 | 0 (0%) |
| homophob* | 1 | 1 (2%) |
| Intersex | 0 | 0 (0%) |
| key population* | 0 | 0 (0%) |
| lesbian | 10 | 7 (17%) |
| LGB* | 41 | 16 (38%) |
| men who have sex with men | 0 | 0 (0%) |
| MSM | 0 | 0 (0%) |
| non-binary | 0 | 0 (0%) |
| non-heterosexual | 1 | 1 (2%) |
| pansexual | 1 | 1 (2%) |
| queer | 1 | 1 (2%) |
| questioning | 0 | 0 (0%) |
| same-gender | 0 | 0 (0%) |
| same-sex | 0 | 0 (0%) |
| sex characteristics | 0 | 0 (0%) |
| sexual identit* | 2 | 2 (5%) |
| sexuality | 3 | 2 (5%) |
| sexual minorit* | 1 | 1 (2%) |
| sexual orientat* | 8 | 6 (14%) |
| trans* | 8 | 6 (14%) |
| transphob* | 1 | 1 (2%) |
| **Totals** | | |
| Acronyms | 41 | 16/42 (38%) |
| Sexual Orientation | 47 | 18/42 (43%) |
| Gender Identity | 12 | 8/42 (19%) |
| **Overall Total** | **100** | **22/42 (52%)** |

#### *iii. Meso level critical discourse analysis*

Due to the clustering of terms related to LGBTQ + communities (e.g. 'lesbian, gay and bisexual'), 60 paragraphs were extracted for analysis which included all usages of the LGBTQ + search terms. Four types of framing were identified (see Table 4 for example quotes):

#### *a. Decontextualized presentation*

Most frequently LGBTQ + people were presented in a decontextualized frame (accounting for 45% of coded extracts), where they were mentioned, but with no reference to inequities or specific care needs. This included: descriptors of the local population, with quantification of LGBTQ + people or qualitative descriptors of diversity (see quotes 1 and 2, Table 4); LGBTQ + people being included in lists of minoritised or marginalized groups, but with no explanation of why they were grouped together, or any specific needs (quote 3); reference to the paucity of LGBTQ + data, where the focus was on 'closing the gap' in terms of data, rather than in care delivery (quote 4); and reference to LGBTQ + people in glossaries, references and appendix lists.

#### *b. Partially contextualized presentation*

The second framing identified (around 25% of coded extracts), was partially contextualized presentations. Frequently this framing involved inclusion of LGBTQ + communities within a list of potentially minoritised or marginalized groups. However, unlike the examples above, the strategies made reference to them having specific care needs (quote 5), although the nature of those needs was not made explicit. In some instances this included identification of LGBTQ + communities as a 'PLUS' group within the Core20PLUS5 initiative (quote 6).

#### *c. Contextualized presentation*

The third presentation identified (around 25% of coded extracts, and identified across 7 strategies) was contextualized references. In these examples LGBTQ + people were referred to, and that reference was linked to a specific health or care need. These included: strategies making reference to poorer health outcomes e.g. higher levels of mental health problems amongst LGBTQ + communities, elevated levels of isolation, or higher rates of

**Table 4** Example quotes from the integrated care system strategies

| | Quote | Presentation |
|---|---|---|
| 1 | *'An estimated 11–15% of our residents are lesbian, gay or bisexual. An estimated 2,500 transgender residents.'* (Strategy 35) | Decontextualized |
| 2 | *'[Name] is a diverse County in both communities and geography. From areas of great wealth to extreme deprivation, metropolitan cities to coastal rurality, and a vast range of ethnically diverse, faith and belief communities, LGBTQ + communities and people with disabilities.'* (Strategy 39) | Decontextualized |
| 3 | *'Social inclusion groups - domestic abuse, exploitation, homelessness, learning disability, autism, gypsy and traveller families, asylum seekers/refugees, unpaid carers, physical disabilities, LGBTQ+, services personnel & (families & veterans), drug and alcohol misuse, looked after children, ethnic minority groups, prisoners and their families.'* (Strategy 21) | Decontextualized |
| 4 | *'The ICS research and innovation approach should reference the ICS Partnership strategy and have a clear focus on addressing some of the data insufficiencies, especially around granular data on ethnicity, sexual orientationand faith in performance data sets. This sits alongside a programme of deep dive explorations of inequalities in outcomes and service uptake in different communities.'* (Strategy 12) | Decontextualized |
| 5 | *'There are many social, economic, and environmental factors that can limit a person's ability to be healthy, creating health inequalities. Some population groups are at greater risk of poor health due to social and economic factors like where they live, their income status, race, ethnicity, disability, and sexual orientation.'* (Strategy 11) | Partially contextualized |
| 6 | *'NHS partners will commit to increase the focus on reducing inequalities in healthcare using the 'Core 20 Plus 5', an NHS England health inequalities framework, to support local health services to focus action on: people living the most deprived neighbourhoods (Core 20); locally identified priority groups (Plus). Our Places each identified their priorities groups. Examples include people from ethnic minority heritage, Gypsy, Roma and Traveller communities, asylum seekers, people with learning disabilities, homeless, LGBQTrans communities. Five clinical areas that will impact significantly on health inequalities if we accelerate improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension and high lipids.'* (Strategy 25) | Partially contextualized |
| 7 | *'Some groups and communities are much more likely to experience poor health outcomes. For example, LGBTQ + have higher rates of common mental health problems; life expectancy for the Gypsy, Roma Travellers community is approximately 10–12 years less than that of the non-Traveller community; and men and women who are homeless at or around the time of their death live 31 and 38 years fewer than the average respectively.'* (Strategy 2) | Contextualized |
| 8 | *'Overall cancer screening uptake is also lower in people with learning disabilities compared to those without a learning disability. Nationally, it is recognised that cancer screening rates are also lower in people with severe mental illness and among Transpeople.'* (Strategy 30) | Contextualized |
| 9 | *'The National Cancer Patient Survey shows the inequitable experience across the cancer pathway for some groups, specifically those from our most deprived communities, those who identify as Black or Asian or as LGBTQI+.'* (Strategy 9) | Contextualized |
| 10 | *'Staff shortages and pressurised environments can often mean some staff don't have the time to listen or consider the specific health and care needs of individuals, or their backgrounds, for example ethnicity, neurodiverse people and trans people'* (Strategy 11) | Contextualized |
| 11 | *'LGBT + inequalities - Ensure LGBT + people with common mental health issues receive timely and culturally sensitive support through IAPT and specialist services (IAPT dataset).'* (Strategy 12) | Contextualized |
| 12 | *'Over a third of young people who identify as gay or lesbian report at least occasionally experiencing discrimination because of their gender, and this rises to around 40% for young people who identify as bisexual or pansexual, or transgender.'* (Strategy 28) | Contextualized |
| 13 | *'Teachers are struggling to cope with issues their students present with due to lack of time, training or awareness of what support is most appropriate. An increasing issue at present is young people who are struggling with their gender identity, particularly common among those with autism.'* (Strategy 3) | Problematizing |
| 14 | *'We will: (…) Continue to develop services to support schools, children and young people in crisis and their families, children and young people with autism, eating disorders and issues relating to transgender; Develop a digital single point of access for emotional health and wellbeing.'* (Strategy 27) | Problematizing |

smoking (quote 7). Another contextualized presentation was description of inequities in care e.g. lack of recognition of specific healthcare needs, care not meeting the needs of LGBTQ + people, lower rates of uptake for cancer screening (quote 8), or inequitable care experiences (quotes 9). This included one example which described the inability of staff to '*consider the specific health and care needs of individuals, or their backgrounds' for example ethnicity, neurodiverse people and trans people*', *due to 'staff shortages and pressurized environments' (quote 10).* There were also descriptions of LGBTQ + specific services run by the voluntary sector, and consideration of how inequities might be addressed at a service level (quote 11). It was extremely rare for strategies to link LGBTQ + needs or inequities to structural forces; only four references were identified across two strategies. One strategy made reference to the need to tackle homophobia, transphobia and structural discrimination in the workforce. A second strategy described the prevalence of experiences of discrimination amongst young LGBTQ + people (quote 12).

#### *d. Problematizing presentation*

On rare occasions (around 5% of coded extracts), descriptions of LGBTQ + communities had a problematizing frame. All examples of this related to the trans community. On these occasions there was no mention of trans inclusive care or the specific health or care needs of the

trans community, only problems associated with being trans. One strategy made reference to 'issues related to transgender' and another talked of 'people struggling with their gender identity' (quotes 13 and 14). In both instances these references were in sections related to autism and learning disability with no explanation as to why the trans community specifically had been included here, and with no other references to the trans community elsewhere within the strategy.

## Discussion and macro level critical discourse analysis

### Main findings

Policy documents are key data artifacts to contextualize structural inequities at the population health level. This study provides a novel and robust policy analysis with original insights into the ways that the needs of minoritized communities are represented within recent UK health policy with a focus on how LGBTQ + people in particular are included. Almost all Integrated Care System strategies talked about the needs of their populations in terms of age, disability, gender, ethnicity and maternity or pregnancy. In contrast, only 2/3 of strategies mentioned religion, and there were no references to marriage, marital status or civil partnership. When considering sexual orientation and gender identity together, around half of strategies made reference to LGBTQ + people, but only 1/4 of those references provided that vital context about the specific needs of LGBTQ + people, the health inequities they face, or services for LGBTQ + people. When we look at gender minorities in isolation, there were no mentions of intersex people and only eight strategies made reference to trans people. While there were two mentions of inequities in access and delivery of care for trans people, the specific healthcare needs of trans people, including but not limited to trans affirmative care, were not mentioned in any strategies. Additionally, there were a small number of examples where trans people were presented in a problematic frame, focusing only on problems related to being trans. Across all 42 strategies there were only four references to systemic forces affecting LGBTQ + people (homophobia, transphobia and discrimination).

### Implications

In recent years there have been advances in legal protection for minoritized groups in the UK, as well as recognition that they may have different or additional needs, and are exposed to greater potential disadvantage than the majority population [15, 16]. Equality, diversity and inclusion is a core priority for UK health and social care institutions, and is visible in their values, structures, materials, training programmes, as well as in their public images [26]. It is heartening therefore to see that this focus on inclusion is also apparent at a policy level post COVID-19, where there is the potential to leverage regional and national change [27]. Although the capacity of staff to provide truly person-centred care continues to be threatened by pressure on staff due to scarcity of resources [28], and it is evident that some protected characteristics within UK equality law are more protected than others, or more readily prioritized in policies.

With regard to LGBTQ + people it was rare for the specific health and social care needs, inequities, or services to be described within the strategies. This lack of context and specificity means the tone of inclusion is frequently more one of tokenism than purposeful engagement. As an example, 'lesbian', 'gay' and 'bisexual' people were only ever mentioned in the strategies together, which undermines the specific needs of these groups, and their distinct identities. Recent evidence suggests that bisexual people have worse healthcare experiences and worse health outcomes than lesbian, gay or heterosexual people [29]. As such, a better understanding of the health needs across LGBTQ + subpopulations is needed to address these inequities. This is where strategies such as the Core20PLUS5 can offer great value, as they force policymakers to consider who specifically is most at risk of disadvantage and, importantly, why and how [20].

The most significant findings from this work related to gender minorities. Globally, trans and non-binary people are experiencing unprecedented levels of discrimination, violence, and hostility across political, social and institutional spheres [30]. The exclusion of the specific needs of trans and non-binary people from these strategies, alongside the very limited consideration of structural forces, and the problematization of trans people, contributes to and reinforces the experiences of discrimination and exclusion they experience. Indeed, trans and non-binary people have higher rates of communicable and non-communicable diseases, higher rates of health risk behaviours, and experience individual level and systematic barriers to accessing health care [31]. A recent survey found that 70% of trans and non-binary people had experienced transphobia when accessing health care, and 14% reported being refused care from a general practitioner because they are trans [32].

Health services have a legal duty to reduce inequalities in health and social care [16]. While there are clear examples of progress (indeed six strategies showed a depth of consideration for inclusive practice by describing the contribution of intersectionality to experiences [33]) there is still work to do to ensure that all those at risk of inequities are foregrounded and prioritized by those in a position to advocate for them. Crucially, policies drive health agendas, but also shape care– unless we change what is written about minoritised groups in policy,

through evidence-based advocacy such as this work, the scope for change in practice is limited.

Policy analyses aid in substantiating how structural inequities are articulated and enacted by decision-making agencies. As key drivers of clinical practice standards and health system priority setting, critical review of extant policies can provide evidence-based advocacy for inclusive health and social care cultures and equitable care provision. Similar approaches are needed at national and international levels to secure the health, welfare, and safety of LGBTQ + people who globally face criminalization, life endangering penalties, and states of emergency [34].

### Strengths and limitations

The policy documents identified represent a snapshot in time, however they attest to the published priorities, intentions and aspirations of the Integrated Care Systems. As the Integrated Care Systems become more established, a longitudinal analysis of these strategies over time, as they are revised and refined, would enable us to critically appraise their evolution and impact. The methods used in this study and the rigor with which they are applied are a strength, as they enable a deeper understanding of the way minoritised groups are framed. The multi-level approach of critical discourse analysis offers unique insights particularly in the context of inequities and exposes the ways that policies can mitigate, contribute to, or perpetuate discrimination and exclusion.

## Conclusions

Health policymakers are poised to drive improvements in equity through the work they do, and the policies they create which hold themselves, institutions, and health and social care services to account. While the needs of some potentially minoritized groups are well recognized within these documents, LGBTQ + people are marginalized. Further work is needed to enhance equality, diversity and inclusion practices, and to advocate for those most vulnerable to inequities.

**Acknowledgements**
N/A.

**Author contributions**
KB conceived of the study. KB and DB acquired the funding for the study. KB led the analysis and the writing of the manuscript. DB, WR, CN and RH contributed to the analysis and interpretation of the data, and edited and approved the manuscript.

**Funding**
We are grateful to the King's Better Health & Care Futures initiative for providing crucial support to enable this work. https://www.kcl.ac.uk/research/better-health-care-futures.

**Data availability**
The strategies that form the data are publicly available via the websites of each Integrated Care System.

## Declarations

**Ethics approval and consent to participate**
was not required for this study as it involved the analysis of publicly available policy documents.

**Competing interests**
The authors declare no competing interests.

Received: 7 October 2024 / Accepted: 10 March 2025
Published online: 02 April 2025

**References**

1. World Health Organization. Health Equity 2024 [Available from: https://www.who.int/health-topics/health-equity#tab=tab_1
2. Zeeman L, Sherriff N, Browne K, McGlynn N, Mirandola M, Gios L, et al. A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. Eur J Pub Health. 2019;29:974–80.
3. Medina-Martinez J, Saus-Ortega C, Sanchez-Lorente M, Sosa-Palanca E, Garcia-Martinex P, Marmo-Lopez M. Health inequities in LGBT people and nursing interventions to reduce them: A systematic review. International Journal of Environmental Research & Public Health [Electronic Resource]; 2021.
4. Christian L, Cole S, McDade T, Pachankis J, Morgan E, Strahm A, et al. A biopsychosocial framework for Understanding sexual and gender minority health: A call for action. Neurosci Biobehavioral Reviews. 2021;129:107–16.
5. Hatzenbuehler M, Lattanner M, McKetta S, Pachankis J. Structural stigma and LGBTQ + health: a narrative review of quantitative studies. Lancet Public Health. 2024;9:e109–127.
6. Sexual Offences Act: an Act to amend the Law of England and Wales relating to homosexual acts. (1967).
7. Local Government Act: Sect. 28. (1988).
8. House of Commons Library. The 20th anniversary of the repeal of Sect. 28 of the Local Government Act 1988. 2023.
9. Civil Partnership Act. (2004).
10. Marriage. (same sex couples) Act, (2013).
11. Gender Recognition Act. (2004).
12. ILGA World. Laws On Us: A Global Overview of Legal Progress and Backtracking on Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics. Geneva; 2024.
13. Human Dignity Trust. LGBT People & the Law 2024 [Available from: https://www.humandignitytrust.org/lgbt-the-law/
14. BMJ Commission on the Future of the NHS. The NHS founding principles are still appropriate today and provide a strong foundation for the future. BMJ. 2024;384:e078903.
15. The Equality Act. (2010).
16. Health. and Social Care Act, (2012).
17. Stonewall. LGBT in Britain: Health Report. 2018.
18. LGBT Foundation. Hidden Figures: LGBT Health Inequalities in the UK. 2023.
19. NHS England. Designing integrated care systems (ICSs) in England: An overview on the arrangements needed to build strong health and care systems across the country. 2019.
20. England NHS. Core20PLUS5 (adults)– an approach to reducing healthcare inequalities 2021 [Available from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
21. Fairclough N. Discourse and social change. Cambridge: Polity; 1992.
22. Kang M, Lessard D, Heston L, Nordmarken S. Introduction to women, gender, sexuality studies. Amherst, Massachusetts: University of Massachusetts Amherst Libraries; 2017.
23. Rosa W, Weiss Goitiandia S, Braybrook D, Metheny N, Roberts K, Behrens M et al. The LGBTQIA + Inclusion in the global health policy agenda: A critical discourse analysis of the lancet commission archive. PLoS ONE. 2024.
24. Hamilton H, Tannen D, Schiffrin D, editors. The handbook of discourse analysis. 2nd ed. Edinburgh, UK: Wiley-Blackwell; 2015.
25. Fairclough N. Critical discourse analysis: the critical study of Language. Oxford, UK: Routledge; 2010.
26. NHS England. NHS equality, diversity, and inclusion improvement plan. 2023.
27. NHS South CaWCSU. How are ICS Strategies and Joint Forward Plans Addressing Health and Healthcare Inequalities. 2024.

28. Care Quality Commission. The state of health care and adult social care in England 2023/24. 2024.
29. Cross H, Bremner S, Meads C, Pollard A, Llewellyn C. Bisexual people experience worse health outcomes in England: evidence from a Cross-Sectional survey in primary care. J Sex Res. 2024;61(9):1342–50.
30. Human Rights Campaign Foundation. The Epidemic of Violence Against the Transgender and Gender Non-Conforming Community in the United States. 2023.
31. Connolly DJ, Muschialli L. A call to action for equitable care for trans and non-binary people. Lancet. 2024;403(10422):139–40.
32. TransActual. Trans lives survey 2021: enduring the UK's hostile environment. 2021.
33. Crenshaw K. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. Univ Chic Legal Forum. 1989;1989(1):139–67.
34. Human Rights Campaign. National State of Emergency for LGBTQ + Americans 2023 [Available from: https://www.hrc.org/campaigns/national-state-of-emergency-for-lgbtqamericans

## Publisher's note