Keywords Health promotion/Health inequalities/Transgender/Health checks

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In this article...

- Why health promotion is important
- Tackling health inequalities in the transgender population
- Could health checks be a useful targeted intervention in this group?

Meeting the health promotion needs of the transgender population

Key points

The transgender community experiences significant healthcare inequalities

These healthcare inequalities negatively impact quality of life, life expectancy and disease-free life expectancy

Effectively targeted health promotion may go some way to reducing these inequalities

Practice nurses could have a key role in delivering health promotion to this population

More exploration, research and discussion around this topic is needed

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Abstract Evidence is mounting that the transgender community experiences significant healthcare inequalities due to multiple and multifactorial social and lifestyle factors. The principle that prevention is better than cure is a key part of public health policy in the NHS. Other populations at risk of poorer health, including people with a learning disability or those with certain mental health problems, benefit from enhanced surveillance in primary care through annual health checks. This article proposes that a similar service could be extended to consenting transgender individuals with the practice nurse offering a tailored review. This proposal would need developing in consultation with transgender community groups but is an option worthy of further discussion and debate.

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Evidence is mounting that the transgender community experiences significant multiple and multifactorial healthcare inequalities due to social and lifestyle factors. This article examines this evidence, along with the value of health promotion and the role of practice nurses in improving the provision of health promotion to the transgender population.

Transgender terminology

'Trans/transgender' is an umbrella term for any individual whose gender identity differs from, or does not sit comfortably with, the gender they were assigned at birth. Trans people may also describe themselves by numerous other terms such as 'non-binary', 'non-cisgender', 'gender queer' and 'gender fluid'. A useful glossary of terms can be found on the Stonewall website (Bit.ly/StonewallGloss).

A trans person may take steps to live more closely with the gender with which they identify, including in some cases medical interventions such as surgery and hormone therapy. This article explores the transgender population generally and not gender reassignment or related medical interventions.

Health promotion

The principle that prevention is better than cure has underpinned effective public health policy in the UK for over 150 years. The Department of Health and Social Care (2018) defined health promotion as "reducing the chances of problems from arising in the first place". A year later, *The NHS Long Term Plan* (NHS, 2019) identified supported self-management as vital in the upstream prevention of avoidable illness, which involves educating and signposting people to make better decisions about their health.

In healthcare there is ever-increasing understanding of how lifestyle factors can contribute to poor health in later life. Furthermore, growing research helps guide clinicians' knowledge of how to influence

human behaviour to reduce the global health burden of chronic diseases, for example around smoking cessation (Global Burden of Disease 2015 Respiratory Disease Collaborators, 2017). The NHS faces the challenge of providing the most evidence-based, effective health promotion to adapt to the evolving landscape of its population and improve the health of the general public. This also helps ensure its own longevity, as the financial cost of chronic conditions – particularly with an ageing population – is vast. With good-quality, timely health promotion being more important than ever, the NHS has proposed making every contact count (Bailey et al, 2012).

The Global Burden of Disease study (Bit.ly/WHOGBD) highlighted that the chronic diseases that cause the most deaths globally, as well as years of healthy life lost, share many of the same behavioural risk factors:

- Smoking;
- Poor diet;
- Hypertension;
- Obesity;
- Alcohol and drug use;
- Air pollution;
- Lack of physical activity (Yach et al, 2004; World Health Organization (WHO), 2002).

Cardiovascular disease (CVD) is a leading cause of mortality and morbidity (NHS England, 2019), and is strongly associated with these behavioural risk factors. In 2009, the NHS introduced NHS Health Checks in primary care to support CVD screening, as well as the dissemination of health-promoting information (DH, 2008). NHS Health Checks target all individuals aged 40-74 years who do not have an underlying health condition and aim to ensure they are seen every five years (Box 1).

Health inequalities and marginalised populations

Health inequalities are systemic differences in health between different groups of people, and most research supports the view that they are underpinned by social factors, including:

- Diet;
- Housing;
- Quality of employment;
- Exposure to discrimination or violence;
- Other factors that are not strictly health related but can have a profound impact on an individual's quality of life (Fish and Karban, 2015).

People living in the most-deprived areas of England are nearly four times as likely to suffer from a premature death related to CVD, when compared with those living in the least-deprived areas (Lomas and Williams, 2019). A comprehensive systematic meta-analysis of research, published in 2008, also supports the correlation between positive psychosocial factors – including family and community relationships and social capital or power – and better health (Egan et al, 2008). Research has also found that Black people and those from minoritised ethnic groups experienced inequalities accessing mental health services in primary care (Mental Health Providers Forum and Race Equality Foundation, 2015).

Box 1. **NHS Health Checks**

- Individuals aged 40-74 years without pre-existing conditions are invited for a health check every five years
- The purpose is to identify those at high risk of:
  - Heart disease
  - Diabetes
  - Kidney disease
  - Stroke
- Those aged >65 years are also given advice on the signs and symptoms of dementia
- Questions are asked about lifestyle and family history
- Height, weight, blood pressure and blood tests are checked
- Personalised health advice is given, as well as medicines to reduce blood pressure or cholesterol, for example

"A large government survey of more than 100,000 members of the LGBTQ+ community found that the transgender community are more likely to experience healthcare inequalities"

Since the passing of the Gender Recognition Act 2004, there has been increasing public awareness of the transgender population. Evidence is mounting that this community experiences significant health inequalities due to numerous factors. One such determinant, as defined by Williams and Mann (2017), is 'minority stress' – this is the lifelong, cumulative, psychological and physical effects of having a minority identity.

Other factors that put this community at risk of poorer health include a reluctance to access health services due to:

- Fear of having a negative experience;
- A relative lack of power and informal social support;
- A health and social care system that is not tailored to this population (Westwood et al, 2015).

Although it is widely agreed that this population is understudied (WHO, 2015), a systematic review and synthesis published in *The Lancet* in 2016 concluded that globally "systematic social and economic marginalisation, stigma, pathologisation, discrimination, violence and other human rights violations, including in healthcare, continue to drive and/or exacerbate health inequities" for transgender people (Reisner et al, 2016).

Studies from the US suggest there is an increased risk of myocardial infarction in the trans population compared with the cisgender population, with the level of risk being greatest for transgender men (Alzahrani et al, 2019). Kenagy (2005) found in a study of 182 transgender people that about one third (30.1%) had attempted suicide. This research also found evidence for increased risk of CVD. Although there is limited research investigating rates of cancer among the trans population, a systematic review by Sterling and Garcia (2020) proposed that reduced access to healthcare is likely to impact on screening, which will adversely affect these populations.

In 2018, the Government Equalities Office in the UK carried out a large survey of more than 108,000 members of the lesbian, gay, bisexual and transgender (LGBTQ+) community. It found that the transgender community was more likely to experience healthcare inequalities owing to several behavioural and social factors (Government Equalities Office, 2018). A YouGov survey (Bachmann and Gooch, 2018) commissioned by Stonewall in 2018, focusing exclusively on the transgender and non-binary community (Box 2), also highlighted many social factors that would predispose this population to poorer health. These include:

- High rates of homelessness;
- Domestic violence;

- Lack of social acceptance, including within close family;
- Bullying and discrimination at work;
- Poor experience in the NHS, making them less likely to access these services in future;
- High rates of mental health issues that, in themselves, entail a greater risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease and CVD.

NHS Health Checks

Some populations at risk of poorer health, including those with a learning disability or with certain mental health problems, benefit from enhanced surveillance in primary care through annual health checks. One proposal is that a similar service could be extended to consenting transgender individuals in primary care, with the practice nurse offering a tailored review. It would be an opportunity for health promotion, potentially to reduce the risk of CVD and other preventable life-limiting conditions, while also promoting a better relationship between the trans population and health services.

This would go towards meeting the goals set out in the NHS constitution, of providing a comprehensive service to all, irrespective of, among other characteristics, gender, sexual orientation or gender reassignment (Bit.ly/DHSCNHSConEng). The Nursing and Midwifery Council's (2015) code also views challenging discriminatory behaviour as a primary professional standard to be upheld by nurses.

Box 2. **Stonewall survey findings**

A survey involving 871 transgender people found that:

- 41% of trans people had experienced a hate crime or incident because of their gender identity in the previous year
- 25% had experienced homelessness at some point in their lives
- 12% of trans employees had been physically attacked by customers or colleagues in the previous year
- 41% said healthcare staff lacked understanding of their specific health needs
- 11% had gone abroad for medical treatment to alter their physical appearance, including buying hormones online because of barriers accessing treatment in the UK

Source: Bachmann and Gooch (2018)

"Consultation with local trans community groups in the health check template, structure and invitation design is likely to achieve a better response and uptake as well as a better understanding of the community itself"

Current NHS Health Checks are mainly a CVD screening tool and would need to be adapted into a more holistic model incorporating opportunities, such as discussing mental health. Since 2009, NHS Health Checks have targeted all individuals aged 40-74 years to screen them for their risk of CVD (Department of Health, 2008). This was expected to cost around £4.5bn over 20 years, a cost that was expected to be mitigated by the reduction in ill health.

NHS Health Checks have come under extensive criticism (Capewell et al, 2015; McCartney, 2013), including the view that there were no randomised controlled trials before their implementation and, as such, there is little scientific evidence for their efficacy. A study looking at >4,000 NHS patients found small reductions in CVD in high-risk patients with a complete health check, as opposed to an incomplete one, and an increase in the prescribing of statins (Artac et al, 2013). This latter finding contradicts National Institute for Health and Care Excellence (2010) guidance, which stated that the health checks should reduce the amount of statins being prescribed.

There has been concern that health checks medicalise social issues that should be addressed by government. For example, a small qualitative study by Perry et al (2016) found health checks provided an opportunity for health promotion, which also led, in some instances, to behaviour change; however, there was criticism of the focus on medical and behavioural options, rather than lessening inequalities in the wider social environment. An example of this might be that some individuals do not do enough physical activity and have high cholesterol; it could be argued that, if more green spaces were created, people would be more likely to exercise and improve their overall health. In contrast, a medical model would perhaps advocate statins to reduce cholesterol in lieu of broader environmental changes.

Evidence is conflicting on how NHS Health Checks affect health inequalities. A large cross-sectional study of more than 150 primary care trusts from 2010-2011 found that, at only around 14%, uptake was lower than the government projection of 18% a year (McDermott et al, 2016); this raised questions about clinical and cost effectiveness. However, the study did find that coverage was much higher in the most-deprived areas than it was in those that were the least deprived.

On the other hand, a 2016 study by Cook et al looked at the sociodemographics of uptake and found that individuals identifying as "any other White background" and "Black African" were less likely to make an appointment, suggesting that, in some instances, health checks might actually widen health inequalities. The researchers supported the case for tailoring the invite to the specific population being targeted. As an example, some groups may prefer a discreet invitation, perhaps by text message, rather than a letter, which may be deemed less private.

A randomised controlled trial in 2016 looked at 18 inner-city London GP practices and found poor uptake of health checks, with or without a pre-screening questionnaire, and even with a small financial incentive (McDermott et al, 2016). They found that around 50% were done opportunistically when patients attended the practice for other reasons, suggesting this may be a more effective means of delivery.

A tailored approach

There is a lack of local and national statistics on the transgender population and estimates of the size of the transgender population in the UK vary from 65,000 to 300,000 (Reed et al, 2009). Research from the US has found that within the transgender community there is a need for tailored health promotion (Lopez, 2019). Taken together with research that emphasises the importance of targeted invitations, the means of approaching transgender individuals in offering a health check is likely to be an important consideration.

Stonewall's report – Bachmann and Gooch (2018) – advised that healthcare staff should know when a person's trans-identity is relevant. In the context of offering a health check specifically to this group, there are issues of whether this could be perceived as positive discrimination – Equality Act (2010) – or could actually cause offence, further alienating and reducing the chances of this population accessing NHS services in the future. Reisner et al's (2016) systematic review in

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The Lancet argues for engaging this group in public health efforts. Consultation with local trans community groups in the health check template, structure and invitation design is likely to achieve a better response and uptake as well as a better understanding of the community itself.

Health checks offer a valuable opportunity for health promotion and have the additional benefit of allowing space to create a positive relationship with an individual. Reducing healthcare inequalities for the transgender population requires a national and government driven initiative incorporating the voices of those most affected by these inequalities and is beyond the scope of additional health checks alone. Yet, while acknowledging that health checks are a blunt tool, they could potentially have a net positive result on the general health of this community. Reaching this population would require significant effort on behalf of general practices and a broader campaign that may include leaflets and posters and e-technology, encouraging trans individuals to identify as such on their medical records.

Conclusion

There is strong evidence that the transgender population is likely to experience healthcare inequalities due to numerous behavioural, social and lifestyle factors. It is part of the NHS Constitution for England to ensure equal access to healthcare for all and proactively seek to lessen these inequalities. Health promotion is a tried and tested means to combat health inequalities, reduce the risk of cardiovascular disease and increase life and healthy-life expectancy.

QUICK FACT **14%** LGBTQ+ people who avoid seeking healthcare for fear of discrimination

This article proposes that one way practice nurses could help meet the health promotion needs of this population is via targeted annual health checks. There is a pressing need to address the healthcare inequalities experienced by trans communities, and this article is intended to highlight this issue and further the discussion. **NT**

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