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Navigating healthcare realities: exploring access and engagement for transgender and non-binary individuals in England

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Jason Vickers
Department of Health and Society, The University of Salford, Manchester, UK

Glen Goodliffe
Children's Occupational Therapy Service, Liverpool City Council, Liverpool, UK

Lisa Porter
School of Health and Wellbeing, The University of Worcester, Worcester, UK, and

Vixx Thompson
Expert by Experience and Community Co-Researcher, Manchester, UK

Abstract

Purpose – Engaging transgender, non-binary and gender-diverse (TNBiGD) individuals in healthcare beyond transition-related care is necessary for improving health outcomes. Because of a lack of legislative protections in the UK, this population faces substantial barriers to accessing healthcare, characterised by negative experiences and discrimination. This study aims to explore the healthcare experiences of TNBiGD individuals in England, focusing on access and engagement within primary and secondary care services.

Design/methodology/approach – Adopting a participatory research approach, this study involved 17 TNBiGD individuals in England through online focus groups and semi-structured interviews, conducted in three phases. Ethical clearance was obtained, and participants were recruited via snowball sampling from LGBTQIA+ networks. Thematic analysis was used to interpret the data, with a focus on healthcare engagement and barriers to access.

Findings – Participants highlighted the necessity of equitable healthcare access as a fundamental human right, often hindered by discrimination, restricted access to gender-affirming care and a lack of provider knowledge. Systemic exclusions and identity erasure were identified as major barriers, with participants experiencing misgendering, incorrect use of gender markers and diagnostic overshadowing. Positive healthcare experiences were noted when gender identity was respected and integrated into care.

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Originality/value – This study underscores the significant healthcare barriers faced by TNBiGD individuals in England, highlighting the need for systemic changes to ensure accessible, respectful and inclusive care. Recommendations focus on education, policy changes and further research to address these challenges and improve healthcare outcomes for the transgender and non-binary community [1].

Keywords Transgender health, Non-binary health, Healthcare access, Healthcare engagement, Primary care, Secondary care, Gender identity, Discrimination in healthcare, Gender-affirming care, Cisnormativity, Healthcare barriers, Participatory research, LGBTQIA+ networks, Systemic exclusion, Identity erasure, Diagnostic overshadowing, Equitable healthcare, Human rights in healthcare

Paper type Research paper

Background

Engaging transgender, non-binary and gender-diverse (TNBiGD) individuals in primary and secondary healthcare, beyond transition-related care, is understood to be essential for enhancing health outcomes (Grant et al., 2011; Vincent, 2018). Hudson-Sharp and Metcalf (2016) highlight notable shortcomings in the UK healthcare system's treatment of transgender people, pointing to a lack of health outcome data and prevalent negative healthcare experiences related to gender identity. These experiences range from improper ward placements to inappropriate medical treatments, underscoring the importance of inclusive, evidence-based policies to effectively meet the unique health needs of the TNBiGD community. Demographic data relating to primary care (Saunders et al., 2023) reveal that transgender and non-binary individuals have higher rates of long-term health conditions, such as mental health issues and autism, compared to the general population. In addition, they report lower satisfaction with their GPs, which can impede positive health behaviours and help-seeking actions. They experience less involvement in treatment decisions, and their needs are often less recognised.

The National LGBT Survey by the Government Equalities Office (2018) reveals significant healthcare engagement by transgender and nonbinary individuals in the UK, alongside considerable challenges. Notably, transgender women (87%) and transgender men (89%) report higher interaction rates with healthcare systems, indicating urgent health needs within these communities. However, 21% of transgender respondents reported neglected healthcare needs, 18% faced inappropriate curiosity, and another 18% refrained from seeking treatment because of discrimination fears. While these statistics highlight key issues in health engagement and access, results are self-reported and may not cover all aspects of healthcare engagement. The need to better capture the views of TNBiGD people is crucial to improving health engagement and access.

While official data sources are scant, third sector organisations and charities provide valuable insights into the key issues affecting TNBiGD persons. The Transactual Trans Lives Survey (2021) found that 27% of respondents avoided GP visits for gender or sex-related care, with transgender men and non-binary individuals more likely to avoid such visits. Additionally, 29% faced care denial based on their transgender identity, and 45% cited a lack of GP understanding about transgender needs, a figure that rises to 55% among non-binary individuals. This misunderstanding significantly impacts 87% of respondents, with 23% experiencing substantial effects. The Office for National Statistics Census (Office for National Statistics, 2021) reports that 0.5% of the population (262,000 people) identifies as having a gender identity different from their sex registered at birth; with a population this size, it is incumbent on the health service to provide parity of healthcare access equitable to their cisgender counterparts. However, the lack of necessary skills among healthcare providers and prevailing discrimination reflect broader societal issues (Winter et al., 2016).

The Stonewall LGBT health report (2018) and the LGBT in Britain-Trans Report (2018) further document the unequal treatment and lack of understanding faced by transgender individuals within healthcare settings. These reports advocate for clearer policies and mandatory equality and diversity training for healthcare staff to improve the inclusivity and understanding of transgender health needs.

Given these known disparities and barriers, urgent research is needed to understand the healthcare experiences of TNBiGD individuals in the UK. In spite of the documented impact of minority stress [2], significant research gaps remain concerning the healthcare needs and disparities faced by this community. This research aims to enrich the evidence base by exploring the healthcare experiences of the TNBiGD population, contributing to health equity, improved outcomes and the promotion of inclusivity and human rights.

Research aim

The aim of this research is to explore the experiences of TNBiGD individuals relating to primary and secondary healthcare services within England, focusing on identifying the perceived barriers and facilitators to engaging with, and accessing, healthcare. This study seeks to deepen our understanding of these experiences to inform strategies that improve healthcare accessibility and engagement for TNBiGD people.

Design

This study adopted a participatory research methodology to delve into the healthcare experiences of TNBiGD participants. Underpinned by a relativist ontology and constructivist epistemology, this approach is grounded in principles of co-design, fosters collaboration between researchers and participants, and allows participants to significantly influence both data collection and analysis processes, thereby ensuring a deeper insight into their unique experiences (Greenhalgh et al., 2019). Ethical clearance was granted by the University of Worcester ethics committee [ref: CHLES20210014]. 17 participants aged over 18 identifying as transgender, non-binary, or gender diverse were recruited via snowball sampling from LGBTQIA+ networks. Each participant provided full written informed consent before participating at each stage of the study. Confidentiality was maintained by participants selecting aliases of their choice.

The research was conducted in three phases, adhering to social distancing measures during the COVID-19 pandemic. The initial phase involved an online focus group of six, using the virtual meeting platform Zoom; participants identified key topics for the focus groups in phase two. The second phase included two Zoom focus groups of six, and one of five, for discussions on healthcare access and engagement, with focus groups guided by the schedule of topics developed from the initial focus group. All members from the initial phase of the study were included as participants in the second phase of data collection.

The final phase involved disseminating findings to participants for feedback via a qualitative questionnaire, with six responding. This process allowed participants to reflect on, and contribute to, the interpretation of their experiences, validating the results through direct community input. Participant feedback is presented after each thematic section, ensuring the study accurately reflects the healthcare realities of the individuals who took part in phase three.

Collection of demographic information was specifically requested by participants in phase one, as they expressed it was important to capture the voice, identity and intersectionality [3] of the participants given the subject of this data. The survey on sexuality and gender identity used known terms within the TNBiGD community while also allowing participants to add terms with which they identified. Participants could select or add multiple terms to best describe their sexual orientation and gender identity. Detailed demographic information of the participants, including the full breakdown of ethnic backgrounds, is provided in Table 1; sexuality and gender identity data in Table 2; and reported health needs are in Table 3.

Table 1. Demographic data ($n = 17$)

Demographic characteristics	Frequency	%
Age		
18–30	4	(23.5)
31–40	8	(47)
41–50	3	(17.6)
51–60	1	(5.8)
61+	1	(5.8)
County of residence		
City of London	6	(35.2)
Greater London	2	(11.7)
Merseyside	1	(5.8)
Shropshire	1	(5.8)
Tyne and wear	1	(5.8)
West Midlands	1	(5.8)
Unspecified	5	(29.4)
Ethnicity		
White (British)	9	(52.9)
Any other White background	3	(17.6)
Mixed White and Asian	1	(5.8)
Any other mixed background	1	(5.8)
Any other Asian background	1	(5.8)
Black or Black British (Caribbean)	1	(5.8)
Prefer not to say	1	(5.8)
Highest level of education		
High school	1	(5.8)
College or sixth form	2	(11.7)
Undergraduate degree	7	(41.1)
Postgraduate degree (MSc)	6	(35.2)
Prefer not to say	1	(5.8)
Gross household income		
Below £15,000	7	(41.1)
£15,00–£25,000	6	(35.2)
£35,000–£45,000	1	(5.8)
£45,000–£55,00	1	(5.8)
Prefer not to say	2	(11.7)

Source(s): Table created by authors

Table 2. LGBTQIA+ identities ($n = 17$)

Demographic characteristics	Frequency	%
Sex assigned at birth		
Female	12	(70.5)
Male	5	(29.4)
Sexual orientation		
Asexual spectrum	1	
Bisexual	5	
Gay	2	
Heterosexual	3	
Pansexual	2	
Queer	6	
Androsexual	1	
Unknown (self-selected entry)	1	
One entry	*13*	*(76.4)*
Two entries	*4*	*(23.5)*
Gender identity		
Man	3	
Non-binary	8	
Person with a trans history	2	
Queer	8	
Trans	6	
Transgender man	6	
Transgender woman	3	
Woman	1	
Transfemme	1	
Agender	1	
One entry	*5*	*(29.4)*
Two entries	*6*	*(35.2)*
Three entries	*3*	*(17.6)*
Four entries	*2*	*(11.7)*
Five entries	*1*	*(5.8)*

Source(s): Table created by authors

Data transcription corrected Zoom's autogenerated texts for accuracy, followed by thematic analysis of transcripts to interpret participants' healthcare engagement insights. The procedures used for this involved familiarisation with the data, generating initial codes, searching for themes, reviewing and defining themes and reporting the analysis with vivid, compelling participant extracts, with saturation of concepts achieved across all themes as recommended by Braun and Clarke (2006). This process, conducted over four months by three of the authors, was led by an experienced researcher, with thorough exploration of concepts and consistency of analysis, audit of data set coding and agreement of emergent meaning. Inter-coder reliability was established through triple coding of the first focus group transcript and cross-checking emergent themes throughout the analysis process. Findings were verified by participants in the final study phase. There was a concerted focus on ensuring that the voice of the participants was consistent throughout, maintaining a robust appreciation of their life experiences.

Table 3. Reported health needs

Health conditions and number of conditions reported	Frequency	%
No reported conditions	*n* = 8	
Depression	*n* = 2	
Anxiety	*n* = 3	
Post-traumatic stress disorder	*n* = 4	
Bipolar disorder	*n* = 1	
Mental health (unspecified)	*n* = 3	
HIV+ status	*n* = 1	
Chronic fatigue (unspecified)	*n* = 2	
Fibromyalgia	*n* = 2	
Premenstrual dysphoric disorder	*n* = 1	
Nail patella syndrome	*n* = 1	
Autism	*n* = 2	
Attention deficit hyperactivity disorder	*n* = 2	
Addiction	*n* = 1	
Irritable bowel syndrome	*n* = 1	
Anaemia	*n* = 1	
Ehler–Danlos syndrome	*n* = 2	
Thalassaemia trait	*n* = 1	
Hyperthyroidism	*n* = 1	
Joint degeneration	*n* = 1	
Neurological genetic disorder	*n* = 1	
Sleep apnoea	*n* = 1	
Autonomic dysfunction	*n* = 1	
No health needs specified	*n* = 8	(47)
One health need specified	n = 1	(5.8)
Two health needs specified	n = 3	(17.6)
Three health needs specified	n = 1	(5.8)
Four health needs specified	n = 1	(5.8)
Five health needs specified	n = 0	
Six health needs specified	n = 1	(5.8)
Seven health needs specified	n = 1	(5.8)
Eight health needs specified	n = 1	(5.8)

Source(s): Table created by the authors

Findings

Finding one: healthcare access as a human right

A key theme across the discussions was participants’ belief in equitable healthcare access as a fundamental human right. Many underscored that access to healthcare transcends individual identities and should be universally available, emphasising that this right is inherent to all, regardless of gender identity. For example, A.K. expressed this perspective by connecting healthcare access with human rights:

> I guess I feel like it’s, I know we’re focused on Trans and non-binary but I guess I feel like it’s important for everyone to have access to healthcare. So yes, it’s important for me. But I believe, I guess I believe like, in our country, it’s a human right to have access to healthcare.

This belief in healthcare as a human right was especially pronounced among participants who faced significant barriers to access, barriers that they asserted would not typically be encountered by cisgender individuals. Participants frequently highlighted experiences of discrimination, limited access to gender-affirming care and a pervasive lack of healthcare provider knowledge regarding TNBiGD health needs. These barriers not only obstructed access but also placed an unfair burden on TNBiGD individuals to navigate or overcome obstacles not experienced by their cisgender counterparts.

Seb expressed this disparity clearly, pointing out the inequity of expecting TNBiGD individuals to shoulder responsibilities that cisgender patients are not required to assume:

> You should have access in the same way that cis[gendered] people do or, you know, non-trans people, should be able to access healthcare […] it shouldn't be your responsibility to do stuff that cis people get automatically.

Participants recounted numerous barriers, such as discrimination and inadequate knowledge among healthcare professionals, which significantly hindered their ability to access healthcare as a fundamental human right. These challenges compelled them to adopt various strategies to navigate interactions and secure necessary care. To minimise discrimination and discomfort, participants often adjusted how they presented their identities. For example, E.T. described carefully assessing when to disclose their transgender identity, weighing the potential risks and benefits:

> Sometimes I have to gauge whether it's worth telling somebody I'm trans or not. Will this make a situation harder? Will they then view everything through that lens?

Others, like R.B., found that adopting a 'stealth' [4] approach, where they concealed their transgender identity, facilitated smoother interactions and access to care, in spite of the personal cost of having to present as a gender incongruent to their identity:

> I tend to just go 'stealth' to be honest, to my GP, and just pretend I'm a woman, and just bat off the questions and pretend that I'm just a body when I'm there, and I don't like […] it doesn't make me feel good. It doesn't in any way affirm anything about my gender, but that's the compromise that I've taken to kind of get myself through it.

Participants expressed that navigating access to healthcare, as an essential human right, often involved complex strategies, such as selective self-disclosure of their gender identity or temporarily adopting a socially de-transitioned presentation. These approaches were used to mitigate potential discrimination and discomfort, ensuring access to necessary services in spite of concerns for personal safety and well-being.

A recurring theme in discussions was the call for a healthcare system founded on equality, one that provides comprehensive, compassionate, and inclusive care, which participants viewed as their fundamental human right. Platypus highlighted this need, underscoring the importance of equality in healthcare:

> We're all human beings, we all have our needs, we all have expectations of health services, the health service should be there for us… they should treat everybody in the same way; meeting their needs. And if they're not doing that, they're not actually doing their job to care for you as a human being.

This advocacy for equality was further complicated by the intersectionality of healthcare access, as participants recognised that additional barriers often arose from other facets of their identities, such as race, ethnicity, socioeconomic status, disability, and age. AK elaborated on this complexity, explaining how various aspects of identity can independently or collectively impact access to care:

> There might be more barriers to me, as due to the fact that I am trans and non-binary, but there's also other barriers due to other categories that I fit into[…] different things come into play. It's sort of like that intersectionality idea, that depending on what you're trying to access different things become more or less important in the eyes of the health service. So, sometimes it's being trans or non-binary. Sometimes it's being disabled. Sometimes it's your age. Sometimes it's whether you have a job.

Participant feedback (finding one)

Feedback on this finding highlighted participants' agreement with the findings, recognising them as reflective of their lived experiences. However, participants also highlighted a desire for a more nuanced exploration than what was possible through focus group discussion, suggesting that the broad categorisation of topics might have glossed over the depth and complexity inherent in their healthcare access experiences. Suggestions for future inquiry were to develop a greater understanding of the specific obstacles and facilitators of healthcare and an urgency in addressing disparities in healthcare access, reinforcing this finding's relevance to people's rights to equitable healthcare.

Finding two: systemic exclusion and identity erasure

A theme across the focus groups was the impacts of systemic barriers faced by TNBiGD individuals because of entrenched cisnormative [5] assumptions within healthcare frameworks. Participants noted that these frameworks, built around binary, cisgender norms, often led to awkward and exclusionary interactions, requiring TNBiGD individuals to adapt or compromise. Jackson illustrated this, describing how binary expectations in healthcare settings forced them to navigate misaligned assumptions:

> It was awkward but in a very amusing way, you know, I'll just pee into this [urine bottle] and it's the guy one and I'm like, "how am I supposed to use this?" and it's like, "oh, they think I'm cis, that's okay", that's a mild inconvenience. But for things like birth control for instance, I have to be very open and very, "I am a trans man". I'm never really that open outside of that, I have to be really, really open about that fact, because then I get people asking me, "Why does a man need birth control?" and [I] have to educate them.

Participants felt that healthcare systems built around binary, cisgender identities inherently marginalise non-cisgender people, as participants reported encountering extra barriers whenever their TNBiGD status was flagged in healthcare profiles. This systemic rigidity not only limited their access to care but also underscored a persistent marginalisation of TNBiGD individuals. Ashley encapsulated the challenge, asserting:

> Because somewhere it says in your document, profile, whatever, that you're trans or non-binary that then you're going to face more difficulties to access that health system. It's ridiculous. Full stop.

Having to face such experiences in healthcare was viewed as a common barrier across focus group discussions. Some participants suggested that when they presented at healthcare settings, they were viewed as a difficulty. Participants emphasised that the prevailing cisgender norms within healthcare not only represent a significant hurdle to achieving equitable healthcare but also lead to a profound sense of alienation. Challenges highlighted include rigid administrative systems; inability to accommodate identity changes; use of gender markers that invalidate gender identity; incorrect names being used (deadnaming); and a palpable lack of gender identity understanding.

The effects of these bureaucratic issues within healthcare systems intensified feelings of alienation for TNBiGD individuals, often obstructing access to appropriate care. Gender markers were sometimes altered or reverted, creating confusion and distress in patient interactions. R shared a moment of frustration upon having gender markers changed and the incorrect use of a gendered title:

> It almost seems as if behind the scenes somewhere there's some asterix on third or fourth box that you're in that only they can see and sometimes some people they mess it up and they misgender you or they don't believe in your gender, so they'll call you [the wrong gender]. I've had somebody even changing my initial M/F. I've had someone call me on the phone and they said 'Miss, whatever', and I got so angry because I was like 'why, where, who did they even get this from?

Participants described the impact of systemic cisnormativity in healthcare, which led to the erasure of TNBiG identities and generated significant psychological distress. This erasure was not merely an oversight but was felt as a denial of the legitimacy of TNBiGD identities. Ashley recounted an especially painful moment when a healthcare professional refused to acknowledge their chosen name, insisting on their deadname:

> I've had to swallow someone telling me your gendered name, because he says, 'it says here you're male and I cannot change that'. It's awful. This is disgusting, because, basically, what the system is telling you is you don't exist, we don't regard your reality. And the effect is monstrous in your psyche. They're telling you 'you don't exist' or 'you don't deserve to be accounted for.

The impact of healthcare systems failing to accommodate non-cisgender identities was acknowledged across focus groups. This was highlighted specifically regarding the absence of adequate provisions for TNBiGD individuals within services that ascribe to a cisbinary healthcare framework. Without a place in the healthcare framework, TNBiGD participants often found themselves unaccounted for, which was reported as leading to inappropriate or dismissive responses from healthcare providers. This issue is represented in J.B.'s account, where their identity as a male, non-binary individual created uncertainty among staff, ultimately leading to their premature discharge in spite of an expressed need for urgent care:

> There was a great difficulty in knowing what ward to place me in, as I identify as male and non-binary. That kind of resulted in me being just discharged because they didn't know what to do with me. So, while I was openly saying 'please don't discharge me, I can't manage, I'm suicidal', I was discharged with a handwritten box of 60 sleeping pills.

In spite of the challenges many participants faced, not all experiences were negative. Some recounted moments where their gender identity was respected and seamlessly integrated into care, leading to positive and affirming outcomes. Such experiences reinforced a sense of belonging within the healthcare system, highlighting the positive impact of inclusive practices. Harry recalled a particularly affirming moment:

> When I go to the GP, and they affirm my gender like this, when I walk out… I still remember the first time [they] said to me, Mr., and I was like, 'Oh my God'. And it just feels absolutely amazing.

Participant feedback (finding two)

Participants resonated strongly with this theme, acknowledging the reality of systemic barriers and the erasure they experience within healthcare settings. The feedback emphasised a keen awareness of the systemic nature of these challenges, rather than attributing them to individual healthcare providers. This suggests an understanding among participants that while individual staff members may strive to offer supportive care, they are often constrained by existing organisational limitations. The call for widespread systemic reforms, including enhanced training and more consistent approaches to staff education, indicates a collective desire for foundational changes that could foster a more inclusive and understanding healthcare environment for all.

Finding three: addressing needs beyond gender identity

Participants emphasised that at times difficulties in accessing general healthcare were not because of the complexity of their health needs but rather to how these needs were overshadowed by healthcare professionals' focus on gender identity. This conflation led to the dismissal of legitimate health concerns or unnecessary gatekeeping, where routine care was often redirected or restricted based solely on gender identity. R captured this experience, noting how interactions with medical professionals were shaped by assumptions about their care needs:

> In terms of interacting with the medical system […] they do dismiss, or refuse to outright see us, because they feel that anything to do with us comes under GIC care, regardless of whatever it is.

R’s statement highlights a perception of how healthcare providers can conflate TNBiGD individuals’ healthcare needs with gender-specific concerns, assuming that all issues should be handled by Gender Identity Clinics (GICs). This misconception creates unnecessary barriers to routine care, potentially delaying treatment, and contributes to systemic neglect. By treating TNBiGD health needs as inherently specialised, healthcare systems inadvertently deprioritise their right to accessible, equitable care, reinforcing healthcare inequities that could be alleviated through more inclusive general healthcare practices.

Participants voiced experiences where their health needs were disregarded, attributed solely to their gender identity by healthcare professionals. This misattribution resulted in essential care being delayed or denied, encapsulating a troubling trend of healthcare professionals dismissing patient concerns. Jackson illustrated this issue, sharing how their identity as a trans person often took precedence in healthcare interactions, eclipsing other health needs:

> So, as a disabled person, I need to access healthcare quite a lot. And it’s often quite hard when you first say you’re trans, because they’ll [health professionals] try to lump everything to do with, like your problem, to be ‘you’re trans.

Participants shared experiences where healthcare professionals dismissed or misunderstood their legitimate health concerns by conflating these issues with their gender identity. This reductionist approach led participants to feel that their healthcare needs were either minimised or invalidated, as health professionals often overlooked or misinterpreted genuine health concerns as being secondary to, or even motivated by, gender identity. Angela recounted a particularly distressing experience of seeking treatment:

> I had quite a serious gynaecological issue, so I ended up having to have a hysterectomy several years ago, so that was obviously essential but the price of accessing all that care was basically being misgendered all the time, because […] they would be like, ‘oh you don’t really have this problem, you just, you know, have this gender thing and you’re like you have an ulterior motive.

Participants highlighted that healthcare professionals’ confusion and conflation of biological sex and gender identity further complicated access to appropriate care. When healthcare providers failed to distinguish between the two, participants often found themselves in the position of having to educate providers to receive the necessary support. Dan described the challenges of navigating these misunderstandings:

> I’ve had some very complicated discussions about the fact that your gynaecological stuff and gender stuff are not the same, although there may be significant overlap between the two. That’s still very much work-in-progress and that’s a nightmare.

Participants emphasised the role of community support networks and advocates in navigating the healthcare system, especially when healthcare interactions frequently defaulted to a focus on their gender identity. Many TNBiGD individuals found that having an advocate helped them address health concerns more effectively, minimising the discomfort and misinterpretations that often arose when discussing their needs independently. Jackson shared how relying on an advocate eased his interactions with healthcare providers:

> I don’t really talk to my GP that much; I leave it up to an advocate to talk to them. Because it feels like every time that I talk to them something’s brought up about me being trans and it's not just my one kind of thing to do with my identity. I'm very complex and I'm an individual.

The fear of mistreatment or rejection led some participants to delay or avoid crucial healthcare appointments, a choice that, while self-protective, carried significant health risks. This apprehension towards seeking care stemmed from past experiences of disrespect or invalidation, leaving individuals to manage health concerns alone or with alternative means. Ash explained the impact of distrust:

> It means that I tend to leave things longer or I tend to try and find other ways of dealing with it. If I expect that they're not going to respect me, then I try and avoid seeing them. It’s not usually possible, but it then kind of means that I kind of go in with an attitude that’s already kind of terrified… and it makes the whole thing less productive, the more stressed I am about the service.

This avoidance reflects a distrust towards a healthcare system that, as participants described, often perceives TNBiGD individuals as needing “extra special” accommodations, rather than simply addressing their health needs beyond gender identity. This perception fosters a sense of alienation, where TNBiGD patients are viewed through the lens of their gender identity first, rather than as individuals with standard health concerns. R encapsulated this feeling of disconnect:

> I sense this huge disconnect of them and versus us. And so, it looks like we need something extra special than any other person when in reality it's looking at what's being presented, you deal with that, and then you move on with your life.

Participant feedback (finding three)

This theme was highlighted as particularly illuminating by many participants, articulating the overshadowing of holistic healthcare needs by a focus on gender identity. The feedback reiterated frustration with being gatekept from necessary services because of perceptions of their healthcare needs being inextricably linked to their gender identity. The desire for a more differentiated understanding of the healthcare needs of TNBiGD individuals was called for, and for healthcare systems to recognise and address the diversity within these communities.

Discussion

Demographics

This study offers insight into study participants’ demographics, LGBTQIA+ identities, and health needs. The age distribution shows a significant proportion of individuals in their mid-30s, with 47% ($n = 8$) aged between 31 and 40. Geographically, most participants reside in or near London, with 35.2% ($n = 6$) in the City of London and 11.7% ($n = 2$) in Greater London, although 29.4% ($n = 5$) opted not to disclose their location. The majority, 52.9% ($n = 9$), are White (British), suggesting a demographic focus that may limit the study’s broader applicability.

There is a clear inclination towards higher education within the sample, with 41.1% ($n = 7$) holding an undergraduate and 35.2% ($n = 6$) a postgraduate degree. However, 41.1% report household incomes below £15,000 ($n = 7$), and 35.2% ($n = 6$) between £15,000 and £25,000, indicating socioeconomic challenges in spite of higher educational attainment.

LGBTQIA+ identity data reveal a majority assigned female at birth (70.5%, $n = 12$), and diverse sexual orientations were reported, predominantly queer and bisexual. Non-binary participants and transgender men were the most reported gender identities. Allowing participants to select or add multiple terms to best describe their sexual and gender identity showed that there was more diversity in how participants reported their gender identity than sexual orientation, with 70.5% ($n = 12$) using two or more terms to describe their gender identity, in contrast to 23.5% ($n = 4$) of participants who used two terms to describe their sexual orientation.

Reported health needs were varied, with mental health conditions such as PTSD ($n = 4$), anxiety ($n = 3$), and unspecified mental health ($n = 3$) being the most reported. A range of chronic physical conditions such as fibromyalgia ($n = 2$), unspecified chronic fatigue ($n = 2$) and Ehlers–Danlos syndrome ($n = 2$) were reported by participants. This variety highlights the complex healthcare requirements of TNBiGD individuals.

The study's demographic skew towards the Greater London area and a predominance of White British individuals highlights the need for targeted sampling approaches to aim for a broader racial and ethnically diverse representation to ensure findings are reflective of the wider TNBiGD community in England. The choice of some respondents not to disclose their location invites the opportunity for future studies to engage more deeply with regions possibly underrepresented in this research.

The contrast between participants' high educational attainment and the majority reporting household incomes below £25,000 highlights socioeconomic challenges that merit deeper exploration. This disparity suggests the need for an intersectional approach to investigate how systemic marginalisation may restrict access to economic opportunities, even among highly educated individuals. Such an analysis could enrich our understanding of the intersections of identity, health, and socioeconomic status within TNBiGD communities, especially in comparison to cisgender, heterosexual counterparts. The elevated educational levels amongst participants likely contributed to the depth of discussions within focus groups, touching upon sophisticated concepts such as intersectionality and systemic marginalisation.

Reported healthcare needs were significant, with all participants having accessed primary and/or secondary healthcare services. The disclosure of disabilities or long-term health conditions by more than half of the participants underscores the complexity of their health needs, necessitating comprehensive support from various healthcare services. The wide range of conditions reported, from mental health issues to neurological and autoimmune conditions, emphasises the need for healthcare services to be adaptable and inclusive, catering to a broad spectrum of health requirements.

The diversity in gender identity and sexual orientation, with many participants identifying with multiple terms, underscores the importance of adopting flexible demographic categorisation in research. This suggests that gender identity within the TNBiGD could be viewed as a "moving target" that resists static categorisation (Guyan, 2022), underscoring the importance of research methodologies that support and respect diverse identity expressions. This approach is essential for capturing the spectrum of identities within the LGBTQIA+ community, challenging traditional binary and fixed categories.

Transgender and non-binary healthcare as a human right

International human rights frameworks mandate protections for transgender individuals, with the Universal Declaration of Human Rights (1948) affirming that all individuals are born free and equal in dignity and rights, establishing a foundation for equal treatment, whilst the International Covenant on Civil and Political Rights (1976) further prohibits discrimination and guarantees equal protection, with specific interpretations extending these rights to include gender identity. In the UK, these international standards are reinforced by the Gender Recognition Act (2004) (GRA), which legally recognises the gender identity of transgender individuals, enabling them to change their legal gender. Additionally, the

Equality Act (2010) provides comprehensive protections by prohibiting discrimination based on gender reassignment across all public services, including healthcare. Together, these frameworks and UK-specific laws underscore healthcare providers' ethical and legal obligations to deliver non-discriminatory, equitable, and respectful care to transgender individuals.

The findings from our investigation into the experiences of TNBiGD individuals accessing healthcare services highlight a discord between the principles of healthcare equity and the lived realities of these communities within the UK. In spite of the foundational belief in healthcare as a fundamental human right, deeply ingrained within British society, and the legislative frameworks, findings show that while participants understand they have a right to equitable access to healthcare, there is a belief that equitable care is not always received.

Participants also report that they often need to navigate healthcare challenges because of a lack of understanding and bias from healthcare providers and from within healthcare systems. While the GRA has historically been celebrated for its progressive stance in allowing individuals to legally change their gender identity without the prerequisite of sterilisation (Hines, 2020) and the Equality Act (2010) prohibiting discrimination based on gender reassignment, our findings underscore a troubling gap between policy and practice as experienced by participants. In April 2025, the UK Supreme Court ruled that the protected characteristic of "sex" under the Equality Act (2010) refers exclusively to biological sex. This ruling has significant implications for how single-sex services and sex-based rights are interpreted in UK law. While the judgment clarified that this does not remove or reduce protections for transgender individuals under the characteristic of gender reassignment, it has introduced new uncertainty for nonbinary individuals and for those without legal gender recognition, including those who do not hold a Gender Recognition Certificate. The decision underscores both the enduring relevance of the Equality Act (2010) and its limitations in addressing the full diversity of gender identity. This legal context frames our study, which seeks to foreground the lived realities and systemic barriers faced by TNBiGD people navigating healthcare under these evolving conditions. The views expressed in this study highlight that UK citizens are facing barriers to accessing healthcare that are antithetical to the ethos of healthcare equity championed by UK legislation because of their gender identification.

An explanation of this finding is that these experiences are because of cisnormative frameworks, the beliefs and assumptions that an individual's gender identity matches the sex they were assigned at birth, as the norm or default. Such assumptions fail to recognise or accommodate the spectrum of gender diversity, effectively marginalising TNBiGD individuals. Such systemic inadequacies are compounded for individuals with intersecting identities, where dimensions of race, ethnicity, socioeconomic status, and more exacerbate health inequalities (Zeeman et al., 2019). The intersectionality of these identities amplifies the impact of discrimination and stigma, further distancing healthcare access from the realm of universal human rights.

Study participants also expressed that having their gender identity recognised and affirmed in interactions was crucial for their access and engagement. This finding aligns with other qualitative research, showing that TNBiGD participants view understanding and acceptance of their gender identities as a key aspect of respectful treatment by healthcare professionals (Carlström, Ek, & Gabrielsson, 2021). This finding highlights that TNBiGD individuals often perceive receiving suboptimal care and seek better healthcare experiences. A comparison with a US Transgender Health Initiative survey shows similar challenges: of 60% of participants who had regular primary care providers, only 43% felt comfortable disclosing their gender identity, with 15% reporting discomfort discussing transgender-specific needs and 20% needing to educate their providers (Bradford, Reisner, Honnold, & Xavier, 2013). Notably, phenomenological enquiry has identified that emotional responses during healthcare interactions can significantly influence feelings of disenfranchisement or empowerment among transgender individuals following healthcare interactions, and there is a need for further research to understand how these emotional dynamics shape healthcare engagement (Roach, 2024). Positive interactions with healthcare providers are significant as they can either facilitate or deter future engagement with healthcare services. Individuals who encounter negative experiences are more likely to delay or avoid seeking care in the future. This reluctance poses significant risks to individual health and well-being and highlights a critical ethical failure within the healthcare system to uphold principles of equity, dignity, and respect for all individuals.

Systemic issues hindering access and engagement

Participant accounts highlighted pervasive discrimination faced by TNBiGD individuals within healthcare systems, underscored by a reliance on biological essentialism [6] within healthcare settings. From participant accounts, these assumptions failed to recognise the complexity of gender identity, which is influenced by a myriad of social and cultural factors, thereby perpetuating systemic barriers to equitable healthcare access. The experiences of TNBiGD individuals within healthcare settings frequently reflect systemic inequities and prejudiced practices that undermine the very principles of healthcare equity (Skuban-Eiseler, Orzechowski, & Steger, 2023).

The participants' experiences suggest that the entrenched cisnormative structures within healthcare have not only influenced administrative procedures and clinical interactions but have also shaped the delivery of care in ways that were perceived as exclusionary or outright discriminatory towards TNBiGD individuals. This is consistent with findings from Teti, Kerr, Bauerband, Koegler, & Graves (2021) within an American context, who highlighted a universal challenge of lacking knowledge and sensitivity as barriers to transgender healthcare access. Such deficiencies in care provision can lead to a range of negative outcomes, from adverse healthcare experiences to harassment and misgendering.

Participants in our study specifically noted a range of challenges that invalidated their identities, such as the misuse of gender markers and deadnaming, which align with the findings of Alpert et al. (2023). These issues were sometimes perceived as an overreach and misuse of their patient information and of exclusive healthcare systems that make patient records not fit for purpose. These experiences also eroded trust in patient–clinician relationships, emphasising a need for healthcare systems to accurately represent and respect individuals' identities. The reported experiences of participants may indicate how binary thinking and cisgender norms are deeply embedded within societal hegemonies and how a binary understanding of gender, conflated with biological sex, does not accommodate the spectrum of gender identities within society. Such a binary framework in healthcare systems contributes to, and perpetuates, the stigmatisation and discrimination encountered by TNBiGD individuals at various levels of healthcare provision (Velasco, Slusser, & Coats, 2022). The lack of recognition of non-binary identities further exacerbates these challenges, highlighting a systemic inflexibility and a critical need for healthcare systems to evolve in accordance with the diverse needs of all patients (Richards, Bouman, & Barker, 2017).

The data reflects a need for developing inclusive healthcare systems that are understanding of the unique needs of TNBiGD individuals. This is an important area of focus, as gender-concordant IDs, alongside legal gender affirmation, have been associated as a determinant of health for influencing psychological distress and suicidal ideation (Scheim, Perez-Brumer, & Bauer, 2020).

Inclusive health-care systems require respecting chosen names and pronouns but also addressing the systemic flaws in health administration systems perpetuated by cisnormative hegemonies (Kronk et al., 2022). Vincent (2018) offers practical recommendations for enhancing inclusivity, including staff training on gender-neutral language and simplifying processes for changing personal information in medical records.

Diagnostic overshadowing in trans and gender-diverse healthcare

The findings indicate that a key issue experienced by participants was frustration with healthcare experiences where their presenting health needs were misunderstood and attributed to their gender identity. Participants reported that in health interactions, it was challenging when healthcare professionals struggled to separate their knowledge of their gender identity from their immediate health concerns, resulting in diagnostic overshadowing. Diagnostic overshadowing, traditionally associated with mental health or intellectual disabilities, occurs when healthcare providers disproportionately attribute a patient's health issues to their most prominent condition (Hallyburton, 2022). This leads to a failure to fully recognise and treat all aspects of a patient's health.

In the context of our study, participants reported instances where healthcare professionals viewed the medical issues that were being raised through the lens of their gender identity, incorrectly assuming presenting issues were directly related to, or exclusively attributed to, their gender identity status. Participants described how this conflation led to instances of inadequate care, inappropriate gatekeeping, and the neglect of healthcare needs unrelated to gender transition or gender dysphoria. Denial of care remains a significant issue in TNBiGD healthcare globally. Studies, including report findings by James et al. (2016) in the USA and Blodgett, Coughlan, & Khullar (2018) in Canda report that transgender individuals can often be denied care because of their gender identity or providers' lack of knowledge. Similarly, a study by Markovic et al. (2021) in Austria found that 13% of transgender participants were denied care. These findings highlight similar barriers to healthcare access within the TNBiGD community outside of a UK context. These findings build on existing knowledge, highlighting that when participants experienced these situations, gender identity was seen to unjustly overshadow their immediate healthcare needs.

The relevance of diagnostic overshadowing in transgender healthcare, while not extensively explored, has been noted by Agana et al. (2019) through case studies emphasising the risk of attributing all health issues to gender dysphoria without considering comorbid diagnoses. Within the TNBiGD community, this experience has been articulated as 'trans broken arm syndrome', providing *in vivo* insight into the frustration and exasperation of having health needs attributed to gender identity (López & Scaramanga, 2024). This underscores a need for healthcare providers to adopt a more nuanced approach to diagnosing and treating TNBiGD patients, acknowledging their health needs beyond their gender identity. Conversely, the failure to recognise mental and physical health needs because of presumptions about the prevalence of mental illness within TNBiGD communities further compounds the issue.

Cho (2019) supports this observation by indicating that historically marginalised groups, including individuals within transgender communities, often face systematic biases that lead to misdiagnoses and adverse healthcare outcomes. This alignment with broader systemic issues emphasises the importance of healthcare professionals adopting an intersectional framework in their practice, considering the complex interplay of identities that affect patients' healthcare experiences and needs. The tensions participants experienced likely reflect systemic healthcare challenges, where professionals often adopt a "trans as condition" lens (Pearce, 2018), framing gender identity as a medical issue alongside other health needs in the healthcare interaction. This positioning results in providers as gatekeepers of care.

Where there were misunderstandings about gender identity within healthcare interactions, participants in our study felt compelled to educate healthcare personnel who lacked the necessary knowledge and skills. This not only placed an undue burden on them to educate whilst in a position of health help-seeking but also highlights a broader systemic failure within healthcare education and training to adequately prepare providers to care for TNBiGD patients. Our participants' experiences resonate with the findings of Floyd, Martin, and Eckloff (2020), who identified a trend of transgender patients being placed in the role of educators for healthcare professionals' lack of knowledge of transgender-specific healthcare needs.

The necessity for healthcare professionals to undertake self-education and training in TNBiGD healthcare competencies cannot be overstated. By fostering a more inclusive and informed healthcare environment, providers can better address the specific and diverse health needs of TNBiGD individuals without falling into the trap of diagnostic overshadowing. Ensuring that patients are not required to educate their healthcare professionals on how to best deliver their healthcare needs is crucial for advancing towards more equitable healthcare practices.

Recommendations

In response to the findings from our study, which illuminated the unique challenges faced by TNBiGD patients within healthcare settings, we propose a comprehensive set of recommendations, aimed at fostering a more inclusive and equitable healthcare environment. These actions are aligned with calls for a better understanding of TNBiGD social determinants and gendered vulnerabilities, as highlighted by Reisner et al. (2016), to develop public health approaches that address unique challenges within this population.

Urgent call for government clarity and rights-based commitment

In light of the UK Supreme Court's 2025 ruling that the legal definition of sex under the Equality Act (2010) refers exclusively to biological sex, we call on the UK Government to urgently provide clear, detailed guidance on how this decision will affect healthcare delivery, including administrative processes, access to services and equality monitoring. This guidance is vital to ensure that providers can navigate care lawfully without undermining inclusive and person-centred practice.

In its judgment, the Supreme Court also reaffirmed that this ruling does not diminish the protections against discrimination afforded to transgender individuals under other provisions of the Equality Act (2010), including those relating to the gender reassignment characteristic. Healthcare providers, therefore, remain under a legal duty to uphold non-discriminatory practices, and to ensure equitable, respectful care for those who are transitioning, have transitioned, or are perceived to be transitioning. These obligations must be embedded in all aspects of healthcare delivery.

However, the current legal framework remains inadequate and uneven in its protection of all TNBiGD individuals. While the gender reassignment characteristic does provide protection for individuals proposing to undergo, undergoing or having undergone a process of reassignment, its scope remains legally unclear and inconsistently applied – particularly for those who are exploring transition, lack a formal diagnosis or do not intend to undergo medical interventions. In addition, nonbinary identities are not explicitly recognised under the Act, and individuals who do not possess a Gender Recognition Certificate (GRC) remain in a precarious legal position, without the full recognition or protection afforded to those with legal gender recognition. This legal gap results in uncertainty for providers, barriers to access and increased vulnerability to discrimination and misgendering in healthcare settings.

We, therefore, urge the Government to reaffirm its commitment to upholding the rights and healthcare access of all gender-diverse people, to clarify the scope of current protections under the Equality Act (2010), and to work in partnership with TNBiGD communities and legal experts to expand statutory protections and ensure inclusive implementation across health and care services.

Implement guidance for inclusive care

Healthcare providers should adopt and implement credible guidance on inclusive and non-discriminatory care for TNBiGD individuals. While the Equality Act (2010) offers some protection from discrimination under the "gender reassignment" characteristic, it is essential that clinical practice strives to provide inclusive, respectful care that affirms the identities of individuals who are nonbinary, gender-diverse or exploring transition without formal legal or medical steps. Implementing inclusive care guidance from professional bodies and respected healthcare organisations, nationally and internationally, will ensure that care provision reflects lived realities and best practice.

Implement mandatory training and self-education

Essential to improving healthcare inclusivity is the implementation of mandatory training on non-discriminatory practice and inclusive communication with TNBiGD patients, including understanding of identities which fall outside the narrow scope of the Equality Act (2010). Incorporating an intersectional approach into training will support care providers in understanding the unique ways in which overlapping identities influence healthcare experiences, allowing for targeted interventions. This training should be embedded within the core curricula of healthcare education programmes for regulated professions, integrated into mandatory staff induction training, and incorporated into ongoing continuing professional development frameworks.

Revise administrative and record-keeping practices

Administrative procedures and record-keeping systems should be examined and revised to better support TNBiGD identities and to enable the sharing and exchange of information. Within electronic health record systems and forms, there should be a clear distinction between legal sex (to meet statutory requirements) and gender identity (to support respectful and person-centred care). Fields for pronouns and preferred names should be added, with the creation of customisable fields for TNBiGD-specific needs. These measures would help ensure that records align with patients' identities and support accurate health tracking and respectful care. Protocols for securely sharing gender identity, pronouns and names across departments should be developed to reduce repeated disclosures for TNBiGD patients. Staff should receive appropriate training on inclusive record-keeping practices, particularly in contexts where legal sex may be at odds with lived identity, as is often the case for nonbinary individuals or those without a Gender Recognition Certificate.

Advance legislative protections

While the current legal definitions of sex are limited to biological sex, and the Equality Act's (2010) protections are tied to the "gender reassignment" characteristic, legislative reform is urgently needed to address the significant legal exclusion of nonbinary people and others who fall outside binary legal categories. Legislative protections should be informed by the lived experiences and healthcare needs of all TNBiGD groups – not only those who are legally recognised. This includes explicitly extending equality protections to nonbinary individuals and ensuring that those who are questioning or exploring gender identity are not excluded from anti-discrimination frameworks, ensuring explicit and comprehensive protection under the law. Developing inclusive, multidisciplinary care guidance in consultation with TNBiGD communities will help ensure legal protections reflect real-world diversity and healthcare need.

Improve demographic data collection

Improving demographic data collection methods to move beyond static categorisation of sex, gender and sexuality can enhance support for, and respect towards, diverse identity expressions. In line with legal requirements, data systems should distinguish between biological sex (as legally defined) and gender identity (as self-identified), allowing participants to select multiple terms for biological sex, gender identity and sexual orientation. This flexibility avoids the restrictive limitations of fixed categories and acknowledges the fluid and multifaceted nature of identity (Guyan, 2022). Where nonbinary identities are not recognised by legal frameworks, inclusive data practices offer an essential corrective, enabling organisations to capture diversity and monitor for disparities that would otherwise remain invisible.

Future research

Research focusing on diagnostic overshadowing within healthcare settings is needed to comprehensively understand its impact on the healthcare access and engagement of TNBiGD patients. This research should aim to elucidate the challenges arising from the conflation of TNBiGD identities with health diagnoses and inform evidence-based advocacy for practice. Further qualitative research is needed to explore the experiences and perceived impacts of systemic biases and unique challenges affecting healthcare access for TNBiGD individuals within the UK to bolster the evidence base to support healthcare engagement. Future research must attend explicitly to the experiences of nonbinary people and those without legal recognition, who are often underrepresented in studies and absent from policy discussions. Applying intersectional frameworks in future research [7] may help shed light on the compounded effects of multiple identities on healthcare experiences. Quantitative research is essential to deepen understanding in this area, particularly through large-scale, inclusive data on TNBiGD health. This includes conducting comparative studies with cisgender counterparts to identify health disparities and evaluating healthcare providers' capacity to deliver inclusive, affirming care. Such research efforts can drive meaningful policy changes, improved support structures and more equitable healthcare services.

Strengths and limitations

This study uses a robust qualitative methodology, deeply engaging with TNBiGD individuals through a structured three-phase approach, effectively capturing the complexity of LGBTQIA+ identities. The methodological approach, including the diverse ways participants could self-identify, provides a rich, nuanced understanding of their experiences, moving beyond binary classifications and encompassing a wide array of educational backgrounds and health conditions. This diversity offers a comprehensive insight into the interplay between health, socioeconomic status and identity, contributing significantly to the study's strengths.

However, the study faces limitations in its geographic and demographic scope, primarily involving participants from southern and central England, aged mainly between 31 and 40, and predominantly identifying as White British. This demographic concentration may limit the applicability of our findings to the broader LGBTQIA+ population across England. Additionally, the noted income disparities among participants, in spite of high educational levels, hint at underlying socioeconomic factors not fully explored, suggesting a potential avenue for future research.

By using a participatory research approach, this study ensures a high level of confidence in the resonance of its findings within the TNBiGD community. The intention is for these findings to be transferable to similar contexts within England, supported by thorough thematic analysis that elucidates participants' views on healthcare access and engagement, systemic exclusions, and the impact of diagnostic overshadowing.

The study's exploration of intersectionality is a significant strength, acknowledging the compounded challenges at the intersection of gender identity and other social determinants. Nonetheless, the findings may not be fully applicable to other regions within the UK or internationally, where different healthcare systems, societal attitudes and legal frameworks might impact the experiences of TNBiGD individuals.

Recruitment through snowball sampling and voluntary participation might introduce self-selection bias, possibly skewing the data set towards certain experiences. While the study aims to present diverse perspectives, there is an acknowledged overrepresentation of white, middle-aged participants. Future research could benefit from targeted strategies to ensure a more inclusive representation, particularly from underrepresented racial and ethnic groups, further enriching the understanding of the healthcare experiences of TNBiGD individuals.

Conclusion

Our study examined the healthcare experiences of TNBiGD individuals in England, uncovering significant challenges and opportunities for improvement. Participants emphasised healthcare as a fundamental human right but highlighted various barriers, including discrimination, limited access to gender-affirming care and gaps in healthcare provider knowledge. These challenges are exacerbated by cisnormative assumptions and the intersection of multiple identities, leading to disparities in healthcare access. Our findings also revealed coping strategies, such as selective disclosure, used by participants to navigate these obstacles. A significant concern identified was diagnostic overshadowing, where healthcare providers conflate TNBiGD identities with health issues. Systemic issues within healthcare systems, such as non-inclusive administrative frameworks and a lack of accommodation for TNBiGD identities, further hinder access and engagement.

Recommendations include the need for comprehensive training for healthcare providers, revisions to administrative systems and legislative protections for gender identity. While current protections under the Equality Act (2010) – particularly the characteristic of gender reassignment – offer some safeguards against discrimination, these remain inconsistently applied and do not explicitly protect nonbinary individuals or those without legal recognition. The recent UK Supreme Court ruling that sex under the Equality Act (2010) refers to biological sex reinforces the urgent need for government guidance to clarify how this legal interpretation affects healthcare access, record-keeping and equality monitoring.

There is an urgent need for the Government to reaffirm its commitment to inclusive and non-discriminatory care by clarifying the scope of existing protections and addressing legal gaps that leave many TNBiGD individuals vulnerable. Without such clarity, healthcare providers face uncertainty in delivering inclusive services, and individuals whose identities fall outside binary legal definitions risk further marginalisation. Legislative protections and national guidance are essential to ensure that all gender-diverse people are recognised and protected in healthcare policy and practice.

Further research into diagnostic overshadowing and the intersectional aspects of healthcare access is essential. Additional research, both qualitative and quantitative, is necessary to develop a more comprehensive understanding of the healthcare experiences and outcomes among TNBiGD individuals and to support rights-based, evidence-informed healthcare reform.

Notes

1. This study was conducted and submitted for publication prior to the UK Supreme Court's April 2025 ruling clarifying that the term "sex" under the Equality Act (2010) refers exclusively to biological sex. While the legal landscape has since evolved, the findings remain relevant for guiding ethical, inclusive and equitable healthcare practice for TNBiGD individuals. The recommendations presented here have been updated to reflect the new legal context, while preserving their foundation in evidence and rights-based care.
2. Minority stress refers to the chronic stress experienced by members of stigmatised minority groups due to societal prejudice, discrimination, and internalised negative attitudes; this stress impacts mental and physical health.
3. Intersectionality is a concept that explains how various social identities—such as race, gender, sexuality, and socioeconomic status—intersect and contribute to unique experiences of privilege and oppression. This approach reveals how individuals face compounded forms of discrimination or benefit from multiple axes of privilege based on their intersecting identities.
4. Stealth refers to a practice where TNBiGD individuals choose to socially "detransition" or not disclose their transgender identity in social, professional, or community settings. This often involves presenting themselves in line with their sex at birth without revealing their transgender history. This may be adopted to ensure privacy and safety or to avoid stigma and discrimination.
5. Cisnormativity refers to the assumption that all individuals' gender identity matches the sex they were assigned at birth, considering this alignment as the norm or default. This belief is systemically ingrained in societal institutions, policies, and cultural practices, often marginalising and invalidating the experiences of TNBiGD.
6. Biological essentialism is the belief that biological factors, such as chromosomes and genitalia, determine gender identity and roles, viewing these characteristics as natural and immutable.
7. An intersectional framework in research involves using structured approaches to examine the layered effects of multiple social identities on lived experiences, particularly within systems of power and inequality. This approach guides researchers in capturing how these overlapping identities shape access, equity, and outcomes in diverse contexts, enabling a nuanced and holistic understanding of social issue.

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About the authors

Dr Jason (Jay) Vickers (he/they) is an experienced researcher, lecturer, a registered occupational therapist and a Fellow of the Higher Education Academy. Jay's areas of research focus on how individuals shape meaning within their lived contexts, and how such meaning influences people's actions and behaviour. Jay is actively involved in LGBTQIA+ equity groups for health and higher education, and post-colonial deconstruction of gender and sexuality. Jay teaches qualitative research in health and social care, and supervises PhD, ProfDoc and DClin students in their research projects. Jason Vickers is the corresponding author and can be contacted at: j.vickers5@salford.ac.uk

Glen Goodliffe (he/him) is a paediatric occupational therapist working in social services. They hold a Bachelor's degree in Psychology, a PGCE in primary education with qualified teacher status and an MSc in occupational therapy. Glen is employed by Liverpool City Council, where they serve as the chairperson for the LGBTQIA+ staff forum, playing a key role in promoting equality, diversity and inclusion within the council. Glen's commitment extends to their research, focusing on improving health engagement and access for transgender, non-binary and queer individuals. They are passionate about creating inclusive environments and advancing the understanding of diverse health needs.

Lisa Porter (she/her) is a Senior Lecturer with over 10 years of experience in academia and 20 years of experience in the health and social care sector. This includes roles in local government contracting, commissioning and managing care provider contracts. Lisa teaches undergraduate and postgraduate courses on quality improvement, healthcare policy, equality and rights. Her research focuses on the wider determinants and experiences of health and social care, particularly among carers, young carers and marginalised groups. Dedicated to academic excellence and social justice, Lisa strives to enhance the quality and accessibility of healthcare services for all.

Vixx Thompson (he/they) has dedicated over ten years to community engagement, outreach and research within the Trans and non-binary community. Their work focuses on empowering individuals physically, mentally and emotionally. Vixx's initiatives include one-to-one sessions, group activities and projects across various groups within the Trans community. They work within key areas such as physical health and well-being, mental health, assertiveness and confidence and sexual health awareness, and are active in research on Trans health issues. Vixx has actively participated in panel discussions at events, promoting Trans participation in sport and sharing the lived Trans experience.