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"Stay home": queer(y)-ing the heteronormative assumptions of COVID policy responses

In early 2020, governments in many countries responded to uncontrolled community transmission of COVID-19 by instituting lockdowns, or shelter-in-place orders, of varying degrees of stringency. As we waited for the roll-out of vaccines to lower the mortality and morbidity of the viral infection, lockdowns were used repeatedly by governments across the world as a public policy measure to reduce transmission. In this chapter, we use the experiences of LGBT+ people during the COVID pandemic in the UK, as captured in research, to "queer" public management. Public policy, and its administration, routinely appeals to the circumstances, needs and preferences of the majority in designing services and distributing resources. There are all sorts of unintended and exclusionary consequences of this that preoccupy researchers interested in minoritized or marginalised populations. The public policy response to COVID-19 is of course no different. At times, this appeal to the majority has pivoted on a heteronormative understanding of what can and should constitute "home" and intimate relationships during times of public health crisis. At other times, a failure to recognise difference in the lives of all citizen-subjects has benefited LGBT+ people, but not sufficiently to fulfil their distinctive circumstances and needs. In this chapter, we demonstrate how policy responses to COVID-19 have tended to reflect a series of heteronormative assumptions that typically underly public management, uniquely shaping the lives, security and opportunity of LGBT+ people.

Introduction

Prior to the COVID-19 pandemic, the National Health Service (NHS) in England had developed an LGBT+[i] inclusion programme for staff. This trained staff who identify as LGBT+ and their allies to be aware of how to deliver inclusive care for this minority population. When staff had completed the training they were given an NHS badge with a rainbow background. In line with many other diversity initiatives, this was meant to be a signal to LGBT+ service-users that they could trust that this person would deliver sensitive and inclusive care. As the first wave of the COVID pandemic swept through the country, the UK Health Secretary at the time – Matt Hancock – was seen numerous times on the news wearing the rainbow NHS badge. Suddenly the rainbow became a symbol for health and social care services, aligned with the government public health message "stay home, save lives, protect the NHS". Buses and trains that had been covered in the rainbow flag for LGBT+ pride, became "for our brave doctors and nurses". Inadvertently the rainbow symbol, which had been a symbol of LGBT+ pride for forty years, was embraced by heterosexual society as a symbol of the fight against COVID. For many people who identify as LGBT+, this felt like erasure (Conway, 2020).

In this chapter, we will argue that this process of erasure, or an ignorance of the fact that LGBT+ people might have had a different experience of the COVID pandemic, and that public management failed to account for this, was widespread. This is the case, even though very early-on in the pandemic, inequalities in its impacts were noted. Higher death rates among people of colour were noted within months of the start of the pandemic (Platt, 2021), and as the pandemic dragged on over years, the higher infection rates and death rates among lower paid people in jobs where it was impossible to work from home, became a marked

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feature (see, for example: Trasberg & Cheshire, 2021). It was not just the novel virus itself that had unequal impact, as Moore et.al. (2021, p. 587) highlight:

> "Just as outcomes of SARS-CoV -2 viral infections have resulted in disproportionate deaths of marginalized populations, many public health responses to the pandemic (e.g. physical distancing, "lock down" periods, working from home, video conferencing) have not impacted all groups equally."

As we will explore in this chapter, this was very much the case for LGBT+ people who were navigating public health measures that presumed and promoted a normative ideal centred around heterosexuality during the pandemic.

A persistent and widely recognised challenge in researching sexual and gender minorities is access to data. People who have historically had their identities criminalised and been subject to harassment and violence may not be forthcoming in revealing their identities (Guyan, 2022). The categories of heterosexual society imposed onto queer lives may not allow LGBT+ people to report their identity in survey instruments (Browne, 2010; Matthews & Poyner, 2020). When we do have population-level surveys that include a question on sexual identity, the small *n* (most countries report around 3-5 per cent of their population as being non-heterosexual) can make meaningful analysis difficult. A common way around this is to either use self-completion, self-referral surveys, or use LGBT+ support and activist organisations as gatekeepers. These are known to exhibit response bias, and LGBT+ organisations, in particular, are more likely to recruit people with particularly complex individual needs as these are individuals who would seek support from these organisations (Renn, 2010). These organisations can also use data selectively for campaigning purposes (McCormack, 2020).

Such challenges in knowing the diversity of populations are often cited in public management as a justification for not being able to effectively support marginalised groups; or for presuming that the needs of a marginalised group are the same as the majority population. In turn, the distinctive needs and interests of such groups are made invisible. In this chapter we argue that this heteronormative erasure was threaded through the administrative measures that were imposed in response to COVID-19, particularly lockdown measures and assumptions around "home", but also the design of economic and social support to households as economic activity was disrupted. Finally, taking our queer-y-ing of heteronormativity in public management further, we consider the ways that public policy reached into the most intimate parts of our lives through COVID measures – limiting who we could meet up with and how, and defining what sexual and romantic relationships were and how they could be conducted. While this was novel for heterosexuals, and led to moralistic sniggering and commentary, we highlight how it was a return to the criminalisation of sexual activity for many LGBT+ people.

Going home?

In early 2020, as the then novel coronavirus spread across the world, public policy entered into people's public and private lives in new and unfamiliar ways for the vast majority of the population. Most immediate were the nationwide "lockdowns", or shelter-in-place orders, that were imposed across many countries. With high levels of COVID-19 transmission

leading to alarming levels of hospitalisations in Wuhan and then northern Italy and Spain, these measures were designed to prevent healthcare systems being overwhelmed, reflected in the aforementioned British public health message: "stay home, save lives, protect the NHS" (National Health Service).

These lockdown orders made a number of assumptions which quickly became apparent. The most basic was that people had some sort of shelter. Many governments rushed through measures to help people who were rough-sleeping and move them into accommodation where they could self-isolate. The intractable policy problem of homelessness became solvable. In the UK context, the "Everyone In" policy essentially solved the crisis of rough sleeping by moving people into empty hotel rooms and providing support for them to overcome the multiple challenges in their lives and move into settled housing (Fitzpatrick, Watts, & Sims, 2020). Bans on evictions temporarily halted the flow of new homeless households into the housing system.

The policy also assumed that the homes people were sheltering in were of sufficient quality (wind and water-tight) and damp-free. Other public health guidance suggested people infected with COVID should self-isolate within a bedroom in their home, using a separate bathroom from the rest of the household, or cleaning the bathroom after use. As health inequalities pre-existing prior to the pandemic began to be reflected in the spread of the disease, the classed assumptions of such guidance became apparent as infection spread through lower-income families and households in overcrowded accommodation, particularly in ethnic minority communities with extended, multi-generational families in one home. This contrasts to those with multiple homes, who could flee cities, or even nations, to escape infection or the restrictions of infection control measures.

Finally, these policy measures also assumed that a family home was a safe place to be. Domestic abuse activists immediately highlighted this fallacy (Carrington *et al*., 2021). For victims/survivors of physical and psychological domestic abuse, lockdowns put them at greater risk. Further, evidence from the UK and Australia suggests that, while more people were contacting domestic abuse helplines during the first lockdown in 2020, fewer incidents were reported to the police because victim/survivors could not escape the domestic environment because of lockdowns (Office for National Statistics, 2020, Moslehi *et al*., 2021).

Akin to the public policy assumptions that underpinned the founding of contemporary welfare states, safe, stable, and often heteronormative homes, were assumed to be available to provide physical and psychological security for all during pandemic lockdowns. For many in contemporary societies, even a cursory assessment of statistics shows this not to be the case. Within the UK in 2020, there were just under an estimated 28 million households, and of these 28.4 per cent were single-person; 2.9 million were single-parent households (Office for National Statistics, 2021). Many of these households suffered with social isolation, loneliness and depression after successive lockdowns dragged on for months, and further restrictions on socialising were imposed (see, for example: Fancourt et.al 2020).

What was the impact on LGBT+ people?

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Turning our focus to LGBT+ people specifically, there is a wide range of evidence that LGBT+ people were impacted negatively by the COVID-19 pandemic and associated public health measures, particularly lockdowns. For many LGBT+ people, moving away from their biological family had allowed them to be who they truly were. Moving "home" could mean a return to living with oppression or even violence. As one LGBT+ person was quoted as explaining in UK research:

> 'my dad has been talking loudly to people on the phone when I'm nearby to say that COVID-19 is the fault of LGBT people…I constantly walk on eggshells…I can't talk about queerness on the phone for fear of discovery' (Hudson et al., 2021, p. 25)

Research on LGBT+ people across six nations highlighted how people in South America reported they felt more "suffocated" because they could not express their LGBTQ+ identity with their family, more so than survey respondents in Europe (Gato et al., 2021).

As highlighted by Statistics Canada, LGBTQ2+ Canadians were twice as likely to experience some form of homelessness in trying to escape such situations, putting them at greater risk during the pandemic (Prokopenko & Kevins, 2020). Such a risk of homelessness, particularly among trans people, was identified in the UK (Hudson et al., 2021). Because of this experience of exclusion or alienation from the family home, many LGBT+ people rely on "families of choice" (Donovan, Heaphy, & Weeks, 2004) or "logical families" (Maupin, 2017) for the psycho-social support offered by a biological family. One participant in research in the UK described how:

> 'as a queer person, I rely on close friendships and non-traditional forms of kinship… [lockdown] is so much easier for people who live in conventional relationships or family bonds' (Hudson et al., 2021, p. 13)

The heteronormative assumptions implicit within lockdown policies – that people would have a nuclear family to provide a safe and secure "home" – alienated this minority group, and many other young people, from the wider social support they routinely rely on.

Moving beyond experiences of specific discrimination and exclusion, it has long been recognised that people who identify as LGBT+ experience broader minority stress which leads to lower health and wellbeing than in the heterosexual and cisgender population (Mann, Blackaby, & O'Leary, 2019; Meyer, 2003). As a result, LGBT+ people experienced markedly poorer mental health during the early months of the pandemic. A systematic review of research in the UK found evidence of poorer mental health among LGBT+ people (McGowan, Lowther, & Meads, 2021) and a major UK-wide survey found the negative impacts were worse for trans and gender diverse people (Kneale & Bécares, 2021). A study of LGBT+ people across six nations thus found that:

> 'quarantine situations have been associated with increased rates of mental health symptoms, amplified by quarantine duration, fear of infection, frustration, boredom, inadequate information, financial loss, and stigma' (Gato et al., 2021, pp. 612-613)

Poor mental health outcomes were particularly marked among transgender and gender-diverse people (noting they were worse before 2020 [Faye, 2021]), with British research during the pandemic finding:

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> 'more than double the percentages of trans young people with a variety of mental health difficulties compared with cisgender respondents. These included having mental health as a significant obstacle, feeling more lonely or isolated, and needing more support from a variety of service providers' (McGowan et al., 2021, p. 2)

Such problems were compounded by reduced access to mental health services and hospital services for gender affirming treatment, which particularly impacted trans people. In the UK, 41% of trans people reported not being able to access medication, compared to 15% of cis people during the pandemic (Hudson et al., 2021).

This overview of the existing research suggests that LGBT+ people did experience the COVID pandemic differently. The response of lockdown measures had a different effect on LGBT+ people that was not commonly discussed in public discourse on responses to the pandemic. In particular, LGBT+ people did not fit into heteronormative assumptions of the "home" or the "household", so they were especially affected by measures seeking to keep people within the home.

The (normative) household as an administrative unit

One specific way in which the design of public policy around heterosexual nuclear families is also clear is the design of welfare systems in economies in the Global North. As highlighted by feminist scholars for many decades (Lister, 1997), the assumption when such systems were designed in the 1930s – 1950s was that welfare support was to be provided for nuclear families, with a male breadwinner in work and a woman providing care in the home (Powell, 2022). Although demographic changes to family structure, particularly lone-parent families, led to changes in welfare systems, the long-term effect of these early policy design decisions is that a considerable amount of financial support provided through the welfare system is focused on households with children. In the UK, the principle focus of this chapter, this privileging of the (working) nuclear family has been reinforced over the last 30 years in two ways. Firstly, through a policy focus on tackling child poverty since 1997; and secondly after 2013 with the introduction of the new benefit Universal Credit with its payments being calculated at the household level.

When the COVID lockdowns in 2020 began, the "automatic stabilisers" of welfare kicked in across nations to soften the sudden disruption to economic activity. Within the UK, there were three main sources of support. First, for those who remained employed, but could not work, employers could claim 80% of an employee's salary, up to £2,500 per month, under the Coronavirus Job Retention Scheme (colloquially known as "the furlough scheme"). Second, people who were self-employed could apply for less regular payments based on their previous earnings.

Finally, people were encouraged to apply for Universal Credit – a form of social security designed to support incomes of people not in work, or in very low-paid work. Detailing the problems with the implementation of Universal Credit would be a book chapter in itself, but after its introduction in 2013, this means-tested benefit has still not been fully implemented and has presented considerable challenges for those seeking adequate public social assistance (National Audit Office, 2018; House of Lords, 2020). Whilst a digital-by-default system facilitated a record number of 1.8 million new claims in the five weeks spanning from the end

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of March during the first national lockdown in the UK, a series of administrative obstacles remained (Summers et al., 2021). Many claimants could not complete the process of proving identity and citizenship through uploading photos of passports, and the telephone support line experienced lengthy delays. Further, built into the system was a five-week delay to processing the first monthly household payment. A decade of austerity and welfare reform, which had undermined the value of working-age benefits, also meant Universal Credit payments were meagre. The UK is one of the worst performing countries in the OECD in terms of its replacement rate for social assistance. In the UK, on average, such payments cover 34% of pre-unemployment income, compared to an OECD average of 58%, lower even than the US (OECD, 2022). The political backlash provoked by the problems with the Universal Credit online platform, which struggled to cope with the amount of web traffic it received, and the impending poverty for hundreds of thousands of households, led the UK Government to temporarily increase *household* Universal Credit payments by £20 (Proctor, 2020).

Using data from a nationally representative survey conducted by Welfare at a (Social) Distance[ii]we can explore the impact of these interventions on LGB claimants compared to heterosexual claimants (Baumberg Geiger et.al., 2023).[iii] Firstly, one might assume that the £20 household uplift to Universal Credit would relatively advantage LGB claimants as they are more likely to be in single-person households – this £20 would be going to a single person, rather than being stretched across a family with children. Despite this, these data show that LGB claimants experienced financial distress in distinctive ways quite early-on in the pandemic when they had begun to claim social security (Table 1). While heterosexual claimants were more likely to have fallen behind on rent or mortgage payments, or other bills and debts, on all other measures of financial distress LGB claimants were more likely to report having experienced these. Skipping meals (23.3% of LGB claimants had done this compared to 18.6% heterosexual claimants) is immediately distressing, but borrowing money (21.4% of LGB claimants) or using savings (23% of LGB claimants) will have a longer-term impacts, reducing people's resilience to any future financial shocks. This evidence of financial distress was also identified by other UK-wide research on the experiences of LGBT+ people more generally in the pandemic (Hudson et al., 2021). This financial distress would have been compounded, particularly for younger LGBT+ people, by welfare reforms since 2010 that maintained certain child-related top-ups within the benefits system but reduced coverage and generosity for younger single and childless households (Brewer, et.al. 2022).

Signs of financial distress	Heterosexuals	Lesbian, gay or bisexual
Fell behind on rent/mortgage payments	10.9%	7.7%
Fell behind on other bills/debts	23.2%	20.9%
Skipped meals	18.6%	23.3%
Borrowing from credit card, overdraft, or bank	16.9%	21.4%
Borrowing from friends and/ or family	20%	23.9%

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Gifts from friends and/ or family	10.3%	15.6%
Used food bank	6.4%	6.3%
Received emergency help from the council or a charity	2.7%	4.4%
Used savings	17.8%	23%

Table 1 – Signs of financial distress amongst claimants between May-June 2020 in the UK

Looking at data on job losses at the start of the pandemic does give some indication as to why LGB claimants were more likely to experience such forms of financial distress. Table 2 suggests that LGB claimants were more likely to be claiming benefits than their heterosexual counterparts because they had been made redundant in the first weeks of the pandemic. As these are descriptive statistics, we cannot infer that claimants were made redundant *because* of their sexual identity. Amongst other things, it is likely to be a product of the sorts of industries LGB people tend to be employed in (particularly gay men): the arts and culture; retail; leisure – all of which were disproportionately affected by national lockdowns in the UK (Tilcsik, Anteby, & Knight, 2015). The LGB claimant population, as recorded in surveys, is also younger than the heterosexual population, and younger people were also more badly affected by the economic disruptions associated with COVID-19 lockdowns. The data thus suggest that the COVID-associated economic disruption did have a differential impact on LGB claimants. These findings were also noted by Statistics Canada (Prokopenko & Kevins, 2020), suggesting this may have been a trend across economies in the Global North.

Reason for starting a new social security claim in 2020	Heterosexual	Lesbian, gay or bisexual
Made redundant due to coronavirus	20.5%	27.8%
Reduced pay/hours	45.7%	46.6%
Lost job NOT due to coronavirus	15.4%	21.0%
Other	40.6%	37.1%

Table 2 – Reasons for starting a new claim in May-June 2020 in the UK

From a public policy perspective, we might have presumed the administrative response to the pandemic was neutral between heterosexuals and non-heterosexuals in terms of supporting incomes. However, the £20 uplift to Universal Credit *per household* disproportionately benefited non-heterosexuals as they were more likely to be in single-person families. Despite this, LGB claimants still experienced greater financial distress during the early stages of the pandemic. Due to the higher rates of redundancy among non-heterosexuals claiming benefits and their disproportionate exposure to labour market disruption, the UK government's furlough scheme may have indirectly benefited heterosexuals as they were more likely to keep their job and thus have their salary (partially) paid. While the furlough scheme was, largely, a success at maintaining incomes and ensuring there were jobs to return to after the lockdowns ended, this differential impact of the scheme has largely not been identified.

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At least in the UK, LGBT+ people had a different experience of the pandemic to heterosexual and cisgender people in terms of employment and household incomes, yet this was largely ignored in policy discussions. Such policies were not explicitly designed on the basis of sexual or gender identity, but because LGBT+ people were invisible in policy design and implementation, the distinctive needs of this minority group were not as effectively met. Ironically, this was the case even though policy was policing *sexuality* in a more widespread way than had been the case in previous decades.

Public management in the bedroom

The administrative assumptions of what is a "household" previously discussed, were not only imbued with heteronormative assumptions on household structure, but also moral judgements on behaviour. With the definition of a household comes moral judgement on sexuality, specifically who can legitimately live with whom, and who can have sex with whom, and where.

In May 2020, a UK Government advisor, Professor Neil Ferguson, was forced to resign after it became public that he had broken the strict lockdown rules by spending nights at the house of a woman he was having an affair with. Such moral judgements on behaviour demonstrate how public management was suddenly reaching into private lives in a way that was alien to the vast majority of heterosexual citizens. The moral ambiguities surrounding this incursion became more apparent as lockdown restrictions were "flexed" later in the pandemic, or in the coverage of pandemic control measures such as contact tracing. Reports from South Korea of people having their secret love affairs made public by the very public processes of contact-tracing led to privacy concerns elsewhere – how dare the state know about such behaviour? (Zastrow, 2020)

Such moral judgements on sex lives codified in law were nothing new for LGBT+ people, and particularly men-who-have-sex-with-men (MSM). Laws criminalising sexual behaviour have a long history for this group. While in many states, such laws criminalising sexual activity have been repealed (although it should be noted how recently this occurred in many states; and at least 57 countries have seen recent legal restrictions passed against homosexuals and transgender people [Flores, 2021) such policing of sexual activity occurred in living memory in most states. Similarly, the privacy concerns of contact tracing were nothing new for MSM, who are encouraged to go for regular sexual health screening and associated contact-tracing if they have an infection or are a close contact.

This complex overlapping of sexual behaviour and public health was particularly apparent when COVID overlapped with HIV/AIDS. Early in the pandemic, LGBT+ people who lived through the horrors of the HIV/AIDS pandemic, and continue to do so, were quick to correct the assertion that COVID was the first global pandemic people had faced (García-Iglesias & Nagington, 2020). However, lockdown-related restrictions on contact also led some to suggest that seeking to end COVID through lockdowns could also end HIV infections. This became a public campaign by the major UK HIV/AIDS charity the Terrence Higgins Trust. As Ledin & Weil (2021) argue though, this view was akin to early public health messages to prevent HIV through promoting sexual abstinence and monogamy. This was naively ignorant of the reality of people's sex lives. This reality was, as one sexual health service in central

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London reported, that 76% of HIV negative MSM were sexually active during the pandemic lockdown.

More broadly, an opportunity was missed in the design of public health policy and associated measures to learn from the earlier HIV/AIDS pandemic. When imposing measures such as lockdowns or mask mandates, many states relied upon social shame and stigma as part of their efficacy (Braksmajer & London, 2021). If you did not follow the measures, you were letting down wider society and putting others at risk by your selfishness. *Ergo* if you were infected with COVID it was your fault for not following the public health guidance. Decades of campaigning and research on HIV/AIDS, led by the LGBT+ community, highlighted how the use of shame and stigma in such a way was self-defeating. It led to people avoiding getting tested and not changing their behaviour when required to do so. Normalising testing and treatment is recognised as the most effective way to control the spread of disease. Stigmatising infection, and blaming individuals for not following good public health behaviours (such as through administrative fines), can cause people to avoid testing, hastening the spread of infection.

Administering a queer COVID

In presenting the collated evidence in this chapter, we have sought to use queer lives to reflect on what was considered 'normal' in public management during the COVID-19 pandemic. Like Lee *et al*. (2008), we are using *queer* as a verb and challenging the heteronormativity of public policy measures brought in to suppress the virus. While in many countries the impact of the pandemic is waning as vaccinations offer protection from severe illness, we can learn from the pandemic to make public policy more inclusive, and deliver the social justice goals that should be at the heart of public services (Oldfield, *et.al.*, 2006).

The first lesson is we cannot allow LGBT+ people to become invisible within public policy and management, both in our practice and our research. Many of the studies reviewed for this chapter highlighted the paucity of *any* research on LGBT+ lives. As one systematic review concluded: "[t]here has been alarmingly little research into the impact of the COVID-19 pandemic on the UK LGBT+ population, despite known pre-existing health inequities" (Kneale & Bécares, 2021, p. 6). Of the 3,343 research projects focused on COVID funded by the UK government competitive research awards to universities, only two explicitly mentioned LGBT+ people.

One explanation for this lack of focus on LGBT+ lives, and how the COVID response might impact on them, might be that public management, in terms of elected and non-elected officials, lacks effective LGBT+ representation. However, for a democracy in the Global North this is not necessarily the case. For example, parliaments across the UK have a substantial number of out, LGB parliamentarians across the political spectrum (see, for example: https://mps.whoare.lgbt/; trans representation is still poorer). The lack of alignment between politicians' and bureaucrats'; interests, and those of the general public who were impacted by specific COVID interventions, has been suggested as a reason why specific restrictions (such as limits on walking in rural areas) were imposed (Greene & Luhiste, 2021). However, if we have a high proportion of out LGB politicians and public managers, this might suggest they could have spoken out on these issues. Without interview data from such people, we cannot definitively say whether these parliamentarians spoke out, or if they chose not to, their reasons for this. This would be a question for further empirical enquiry. That said, there is evidence that those at the centre of power and decision-making during the COVID-19 pandemic were not representative of the wider population they were supposed to serve. This had serious consequences for the effectiveness of pandemic responses and the extent to which these negatively affected some of the groups most exposed to the fall-out of COVID-19. (MacNamara, 2023).

If we do explicitly recognise a differential impact of any aspect of public administration on LGBT+ people, a further lesson is that services need to be reformed to be more inclusive, or specialist services require specific funding to support people. As noted, LGBT+ services from the voluntary sector, particularly those supporting mental health and wellbeing, were overwhelmed during the pandemic and struggled to deliver the services people desperately needed (Hudson et al., 2021). In the UK, this came on-top of over a decade of government austerity that led to funding for such activities to be withdrawn (Colgan, *et.al.*, 2014; Matthews, 2020). Across the globe, the "gender critical" transphobic attacks on LGBT+ inclusion are preventing transgender youth from getting the gender-affirming support and care they desperately need, and also being co-opted by right-wing politicians to support new laws outlawing lesbian and gay relationships (Magni, 2022).

Conclusion

Public management, like many disciplines, has not widely engaged with LGBT+ lives and experiences of discrimination (Lee et al., 2008; Matthews & Poyner, 2020; Smith & Lee, 2014). In this chapter we have sought to demonstrate the damage this may have caused to LGBT+ lives through the policy measures put in place to tackle the spread of COVID-19. In the face of a novel virus that has killed millions and risked overwhelming healthcare systems, the lockdowns and other policy measures were an appropriate response. Over two years on since the first national lockdowns were imposed, we are now understanding far more about their differential impact, and the difficult trade-offs between protecting public health and wider social and economic costs. In this chapter, we have used the evidence that has been gathered on LGBT+ experiences of the COVID-19 pandemic to add to this debate. By "queering" the administration of the pandemic response, we have highlighted the distinctive and negative impacts on LGBT+ people across the globe. Looking ahead to future pandemic responses, we would argue that queer lives need to feature more prominently in the policymaking process if public management is to effectively meet the diverse needs of *all* citizen-subjects.

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[i] There are a variety of acronyms used globally to cover the population that define themselves as non-heterosexual and non-cisgender. In this chapter we have chosen to use LGBT+; if we are quoting a source that uses a different acronym, we use that.

[ii] Welfare at a (Social) Distance was funded by UK Research and Innovation under their COVID rapid response funding scheme, grant number ES/V003879/1

[iii] This survey was conducted between 21 May 2020 and 15[h] June 2020 with a nationally-representative sample of 6,431 claimants. Recruited through a YouGov panel, the survey captured a range of information including claim details, support used when claiming, employment status, experiences of financial difficulty and demographic information. A standard sexual identity question had been asked of all (options: heterosexual; gay/lesbian; bisexual; prefer not to answer) of all respondents.