



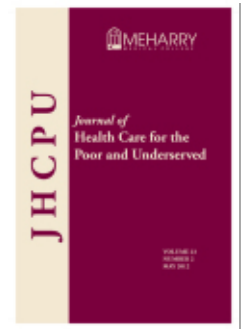
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The Forgotten Minorities: Health Disparities of the Lesbian, Gay, Bisexual, and Transgendered Communities

Lea Mollon

I woke up early that morning for an appointment with my primary care provider; I did not want to be late because I was a new patient and had waited a month for the appointment. Since I had moved across town to attend college, it was no longer feasible to go to my long-time primary care provider (PCP). Although seeing a new PCP made me slightly apprehensive, I had no idea that I would leave the physician's office feeling ashamed.

The office seemed like any other office—pamphlets about women's health were displayed in a holder attached to the wall, there were comfortable chairs for waiting, and magazines were lying on a table ready for perusal. The receptionist at the front desk was friendly and welcoming. At check-in, I began to describe my medical history on a patient intake form that listed the typical medical questions that one would expect. Then I reached the section of the intake form that requested demographic information. One question asked for "Current relationship status" and the response options were: Single; Married; and Widowed. I didn't fit any of those descriptions. I also noticed the omissions of questions concerning sexual orientation and gender identity. Thus, I checked the box for single despite my two-year long relationship with my partner.

When the nurse led me to the exam room to assess my vital signs, she made small talk and we laughed a little, which made me slightly more comfortable. When the PCP came into the room, she introduced herself and shook my hand. We reviewed the information in my intake form together and everything seemed straightforward until she asked me if I was sexually active. I told her that I was, to which she replied, "Would you like birth control?" When I told her that I didn't need it, she proceeded to tell me about unwanted pregnancy and the benefits of birth control, even though I did not request this information. She asked, "So, are you using protection to prevent pregnancy?" I simply said, "I don't have sex with men."

That statement was met with a long pause as she just stared at me. The moment seemed to linger forever and I did not know which of us was more uncomfortable.

"So, you're a lesbian?" she asked, to which I quickly replied, "I'm gay."

I suddenly felt embarrassed. She sighed deeply as if to indicate that what I had just

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disclosed was deeply disturbing. She did not say anything else and stepped out of the room. I was left in the examining room wondering what would happen when she returned. At one point, I considered leaving. She returned with the nurse, who stood in the corner watching as the PCP conducted what seemed like an extremely superficial and rushed physical examination. At the end of my exam, I was given directions to a laboratory for some blood tests and a business card for the provider's office so that I could make a follow-up appointment. I never did get the blood tests and I never returned to that provider.

At the time, I did not suspect that many of my future experiences with health care providers would involve repetitive and awkward explanations about my relationship status, my sexual identity, and why I didn't need birth control.

Unfortunately, experiences like this are not rare for lesbian, gay, bisexual, and transgendered (LGBT) people seeking access to medical services; it seems that many LGBT people have negative experiences with their health care providers and the health care system. In addition to the lack of adequate, informed, and culturally sensitive provider and patient education, the LGBT communities face undue health disparities and inequities that should be addressed. (See below.) Health care professionals should be made aware of these disparities in order to improve quality and cultural sensitivity in care for this underserved population.

On April 15th, 2011, President Obama signed a presidential memorandum regarding hospital visitation and health decision making for same-sex partners. It states that hospitals accepting Medicare and Medicaid must respect patients' advance directives and "respect the rights of patients to designate visitors." These hospitals cannot deny visitation rights based on "race, color, national origin, religion, sex, sexual orientation, gender identity, or disability."¹ This is an important step in protecting the visitation and health decision-making rights of LGBT people but only addresses two of several health inequities that LGBT people experience in their daily lives. Health inequities, such as decreased access to quality preventive care, translate to major health disparities in the community. Some of these health disparities as outlined by *Healthy People 2020*² include, but are not limited to:

- There is a higher prevalence of HIV/STDs, victimization, mental health issues, and suicide among transgender people than among others.
- Gay men have a higher risk of contracting HIV and other STDs, especially those belonging to communities of color, and constitute over half of new HIV infections in the U.S. every year.
- LGBT youth are more likely than others to be homeless, and 30% of LGBT youth report having been physically abused by family members because of their sexual orientation and gender identity or expression.
- Members of the LGBT communities have higher rates of tobacco, alcohol, and drug use than others.
- Lesbian and bisexual females are more likely than others to be overweight or obese.
- Lesbian and bisexual females are less likely than others to get routine care, such as breast and cervical cancer screening. Compounded by increased tobacco and

alcohol use, lesbian and bisexual females may be at a higher risk of developing breast or cervical cancer.

- Elderly LGBT people face additional barriers because of social isolation and lack of social services.

These health disparities are associated with discrimination, social stigma, and negative stereotypes. Research has linked discrimination to a higher incidence of substance abuse, suicide and suicidal ideation, psychiatric disorders, and limited health-seeking behavior. Social stigma and negative stereotypes have been linked with frequent experiences of violence and victimization against LGBT people. In 2008, more than 2,400 LGBT people were victims of hate crimes due to their perceived sexual orientation and gender identity. This represents a 2% increase over the previous year and a 26% increase over the previous two years. Due to underreporting, the actual number of hate crimes against LGBT people is likely higher.³

It is important to note that, for the purposes of research and advocacy, the LGBT populations have been combined into one entity. However, the groups within this umbrella term are distinct and have their own specific health care needs. Many members of the LGBT communities are also part of other communities that face additional challenges and disparities. Their experiences are not uniform; they are shaped by race, ethnicity, primary language, socioeconomic status, geographical location, age, disability status, and other factors. Therefore, they may be vulnerable to the cumulative negative health impacts associated with these factors.^{4,5} For example, LGBT people of color must navigate additional layers of discrimination based on racism, ethnicity, and language. For those living in rural communities, LGBT people face the additional geographic and socioeconomic barriers to quality specialty services particular to rural populations, such as rehabilitative services for disabled persons.^{6,7}

In addition to higher rates of violence, LGBT people also bear the chronic stress associated with systemic discrimination and barriers to access of necessary health services. It is estimated that the ratio of uninsured gay and lesbian adults to heterosexuals in America is two to one.⁶ Lack of legal recognition of same-sex relationships prevents coverage of same-sex partners under some employee health plans. Coupled with lack of support for alternative family structures, LGBT people and their families are more likely to be without health insurance coverage. They may therefore be financially limited in receiving basic, preventive care services. For lesbian and bisexual women, specifically, the lack of recognition and support for alternative family units may result in less of these women bearing children, which is another risk factor for obesity and breast cancer.⁷ For transgender people, many private insurers and state Medicaid and Medicare plans exclude the provision of transition-related care despite statements from the American Medical Association (AMA) that transition-related care is medically necessary. Furthermore, since transgender people may require additional specialty treatments that are often not standard with traditional care, it may be virtually impossible for them to obtain insurance coverage in the private sector.^{5,7}

Although health disparities affecting the LGBT communities are recognized on a federal level by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the

Administration on Aging (AoA), the Centers for Disease Control (CDC), and the National Institutes of Health (NIH), the true nature of these disparities is still in question due to limited data collection. In a recent Institute of Medicine (IOM) report, a committee of experts recommended that data on sexual orientation and gender identity be collected in federally funded surveys, including those administered by the U.S. Department of Health and Human Services (HHS). The IOM also called for expanded federal support for LGBT health research, stating that the NIH should not only “implement an agenda designed to advance knowledge and understanding of LGBT health [but also] encourage grant applications to explicitly address the inclusion or exclusion of LGBT populations in their samples.”⁴

Fortunately, as part of The Affordable Care Act (ACA), new health data collection and analysis strategies will be implemented. This will strengthen federal data collection efforts and provide the HHS the opportunity to collect additional demographic data on sexual and gender minorities in the same way that other demographic data, such as race and ethnicity, are collected. During the IOM committee meeting, it was emphasized that this data be collected in electronic health records that have privacy and security protections to ensure the confidentiality of this vulnerable population, that could be negatively impacted if sexual orientation or gender identity was inadvertently or intentionally revealed.^{5,8}

Currently, the HHS is developing a national data progression plan, which will integrate sexual orientation and gender identity variables into national surveys. Developing consistent methods for collecting and reporting health data will help identify and elucidate the nature of health issues of the LGBT communities. To enhance the quality of this data collection, the HHS and National Center for Health Statistics (NCHS), in conjunction with other federal agencies, are also working on ways to reduce bias in their estimates.⁸

Since LGBT people make up a relatively small proportion of the U.S. population, and since many are unlikely to disclose their sexual orientation or gender identity due to perceived bias, recruiting large enough research samples can be costly and labor intensive.⁵ Consequently, researchers have a difficult time comparing the health care experiences of LGBT people to that of the general population. The IOM suggests that innovative methods to conduct research with small populations should be explored, in addition to developing better methods of data collection, such as the standardization of survey questions regarding sexual orientation and gender identity, to allow for comparison of data across larger studies.⁴

So what does this all mean for us as practicing health care providers and health professional students? How can we, as physicians, pharmacists, nurses, specialists, and other health care providers work together and change health care practice in the U.S. to create a safe space for LGBT patients? How can we directly address these inequities and disparities?

The answer lies in being aware of these health disparities and inequities and being sympathetic to LGBT patients’ needs.⁵ Considering many LGBT people choose not to disclose their sexual orientation or gender identity, and are less likely to seek preventative care or early diagnostic services, it is important to provide a “safe space” for them to disclose health issues and needs.⁷ Using gender neutral language when discussing

personal relationships and having a standardized intake form with additional identifiers for sexual orientation, gender identity and expression, and alternative family units would help create a climate that is sensitive and inclusive. Being sensitive to LGBT health care needs and understanding the stressors associated with the “coming out” process will also allow crucial conversations to occur.

Incorporating awareness education about these disparities and inequities into health professional school curricula and continuing education would allow students and health care providers to address personal feelings and perceptions regarding LGBT people, sexual orientation, gender identity, and expression in general. Specific training that provides information about how to better serve LGBT patients would provide students and practitioners a foundation for working with this vulnerable community; including a psychosocial component as well as appropriate communication skills training could help reduce prejudicial attitudes and discriminatory practice.

Furthermore, as providers, we can help develop and implement specialized programs addressing the health care needs in specific communities and become effective advocates for policy change at the state and federal level. With the increasing evidence of health disparities and inequities and their impact on the LGBT communities, it is important that the state and federal governments create programs to address these disparities.⁹ Including the LGBT community in health research, being informed health care providers, developing the tools necessary for optimal patient care, and making changes to standard practices will undoubtedly improve the health status of a historically forgotten minority.

Notes

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