



How to Close the LGBT Health Disparities Gap

By Jeff Krehely | December 21, 2009

Summary and introduction

In the past decade lesbian, gay, bisexual, and transgender, or LGBT, people have made rapid progress in winning and securing equal rights. Fifteen states and Washington, D.C. now give same-sex couples at least some of the same rights afforded to heterosexual married couples. Even more states offer nondiscrimination protections based on sexual orientation, gender identity, or both. Polling data show that the general public has increasingly positive views of LGBT people and are becoming more supportive of their civil and political rights.¹ In short, heterosexual Americans are finally recognizing LGBT people as a legitimate social minority that should have equal access to our society's basic rights, opportunities, and responsibilities.

Despite this progress, however, members of the LGBT population continue to experience worse health outcomes than their heterosexual counterparts. Due to factors like low rates of health insurance coverage, high rates of stress due to systematic harassment and discrimination, and a lack of cultural competency in the health care system, LGBT people are at a higher risk for cancer, mental illnesses, and other diseases, and are more likely to smoke, drink alcohol, use drugs, and engage in other risky behaviors.

People who are both LGBT and members of a racial or ethnic minority will often face the highest level of health disparities. For example, as the National Coalition for LGBT Health notes, a black gay man faces disparities common to the African-American community as well as those suffered by the LGBT community, and a transgender Spanish-speaking woman, regardless of her sexual orientation, must navigate multiple instances of discrimination based on language, ethnicity, and gender.² A companion CAP brief, "How to Close the LGBT Health Disparities Gap: Disparities by Race and Ethnicity," explores these in more detail.

Health surveys cannot continue to treat populations in isolation: Members of the LGBT community who are members of other populations that are recognized as suffering from health disparities must be allowed to identify themselves fully on surveys, including their sexual orientation and gender identity.

We can only estimate the full extent of LGBT disparities due to a consistent lack of data collection on sexual orientation and gender identity. No federal health survey includes a question on sexual orientation or gender identity, and only a few states ask respondents their sexual orientation or gender identity, severely limiting researchers' ability to fully understand the LGBT population's needs and hindering the development of public policies and programs that seek to improve the LGBT population's health and well-being.

To overcome this lack of data and make it easier for researchers and advocates to get a full and accurate accounting of LGBT health outcomes and needs—and ultimately to close the gap between the health and well-being of LGBT people and the heterosexual population—the U.S. Department of Health and Human Services should establish a dedicated Office of LGBT Health. This office would take the lead in coordinating a consistent and scientifically driven response across HHS to LGBT health issues. A top priority of this office should be to ensure that any federally funded health study that collects demographic information—be it age, sex, race, ethnicity, primary language, or socioeconomic status—must also include questions about sexual orientation and gender identity.

This memo will outline the health disparities LGBT populations face, look at why these disparities occur, and examine why we need better data on these populations and what we can do to solve this problem.

LGBT health disparities³

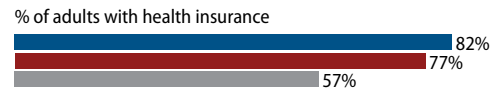
The right-hand columns of Pages 2, 3, and 4 show 18 data points on key LGBT health disparities. They are organized into four categories: access to health care and health insurance, impact of societal biases on physical health and well-being, impact of societal biases on mental health and well-being, and how societal biases lead to engagement in risky behavior.

The indicators show significant disparities in the mental and physical well-being of the LGBT population when compared to the heterosexual population. Members of the LGBT population are less likely to have health insurance coverage and more likely to have to resort to visiting emergency rooms for care. They also have higher rates of some diseases, lower rates of testing and screening for certain illnesses like heart

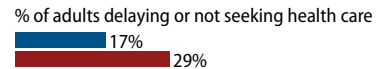
Access to health care and health insurance

■ Heterosexual ■ LGB ■ Transgender

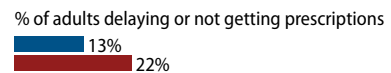
Health Disparity #1: Heterosexual adults are more likely to have health insurance coverage.⁵



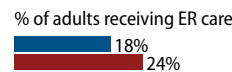
Health Disparity #2: LGB adults are more likely to delay or not seek medical care.⁶



Health Disparity #3: LGB adults are more likely to delay or not get needed prescription medicine.⁷



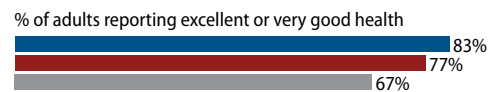
Health Disparity #4: LGB adults are more likely to receive health care services in emergency rooms.⁸



Impact of societal biases on physical health and well-being

■ Heterosexual ■ LGB ■ Transgender

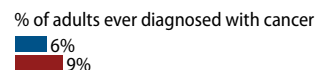
Health Disparity #5: Heterosexual adults are more likely to report having excellent or very good overall health.⁹



Health Disparity #6: Lesbian and bisexual women are less likely to receive mammograms.¹⁰



Health Disparity #7: LGB adults are more likely to have cancer.¹¹



disease, and higher engagement in risky behaviors that can compromise overall health or well-being, such as alcohol and tobacco use.

Many of the statistics presented are based on data collected through the California Health Interview Study, or CHIS. CHIS is one of the very few comprehensive, ongoing state-level health surveys that regularly collects information on sexual orientation. Although statistics on California’s lesbian, gay, and bisexual residents cannot be generalized to the national LGB population, it is useful to analyze California since it has the largest LGB population in the United States. The Williams Institute, a think tank at the UCLA School of Law dedicated to sexual orientation law and public policy, estimates that 1.3 million LGB adults live in California, representing about 15 percent of the estimated 8.8 million LGB adults in the United States.⁴

No national government surveys include questions related to gender identity or expression. To date, Massachusetts is the only state that we found to include a question on gender identity in a government health survey. Several researchers and advocates have done surveys of local transgender populations, and we include data from their work in our review below. Many of these data points can be found in the Movement Advancement Project’s “Advancing Transgender Equality” report from January 2009, which included a meta-analysis of studies on the transgender population.

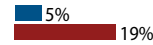
CHIS collects demographic data on race and ethnicity as well as sexual orientation. This data is presented in a companion brief to this report.

Sources of LGBT health disparities

Negative health outcomes for LGBT people are due to the cumulative and intersecting impact of many different factors, particularly their reduced access to employer-provided health insurance, the social stigma that exists against LGBT people, and a lack of cultural competence in the health care system.

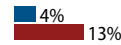
Health Disparity #8: LGB youth are more likely to be threatened or injured with a weapon in school.¹²

% of youth threatened or injured with a weapon



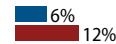
Health Disparity #9: LGB youth are more likely to be in physical fights that require medical treatment.¹³

% of youth in a physical fight requiring medical treatment



Health Disparity #10: LGB youth are more likely to be overweight.¹⁴

% of youth who are overweight

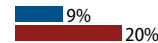


Impact of societal biases on mental health and well-being

■ Heterosexual ■ LGB ■ Transgender

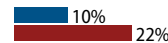
Health Disparity #11: LGB adults are more likely to experience psychological distress.¹⁵

% of adults experiencing psychological distress in past year



Health Disparity #12: LGB adults are more likely to need medication for emotional health issues.¹⁶

% of adults needing medication for mental health



Health Disparity #13: Transgender adults are much more likely to have suicide ideation.¹⁷

% of adults reporting suicide ideation



Health Disparity #14: LGB youth are much more likely to attempt suicide.¹⁸

% of youth reporting suicide attempts



Lack of health insurance

LGBT people lack health insurance for several reasons. First, persistent workplace discrimination and harassment means that LGBT people are more likely to lose or quit their jobs or to not get hired in the first place.²³ A study by the National Gay and Lesbian Task Force and the National Center for Transgender Equality shows that 97 percent of transgender people report being mistreated at work because of their gender identity or expression. For example, transgender people consistently report being verbally or physically harassed, removed from direct contact with clients, or fired without cause. Because most people get their health insurance through their employers, these employment gaps also create insurance coverage gaps.

Second, many workplaces do not provide health insurance benefits for the same-sex domestic partners of their employees. Given the high cost of purchasing private individual health insurance and administrative barriers to accessing coverage, many LGBT people must go without insurance. Research shows that if all employers offered domestic partner benefits, the uninsured rates for same-sex and different-sex unmarried couples would decrease by as much as 43 percent.²⁴

Third, most insurance plans do not cover the specific care that LGBT people need. Transgender individuals are often unable to access even basic preventative and primary care due to insurance exclusions. Similarly, because discriminatory health care practices lead LGBT people to either not seek preventative treatment or to receive low-quality treatment, they are more likely than others to have HIV/AIDS or certain cancers. Insurance companies almost always classify these diseases as pre-existing conditions, which means the people who have them are either ineligible for coverage or are charged exorbitant rates when they seek coverage in the non-group market.

Without insurance, people are less likely to be able to afford regular health screenings and treatment for specific health problems. Such barriers to care often delay treatment until a condition is extremely difficult or even impossible to manage or cure.

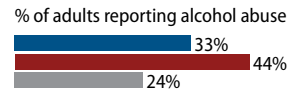
LGBT stigma

Another reason LGBT people tend to have worse health status than heterosexuals is the social stigma around being lesbian, gay, bisexual, or transgender. Because of this stigma, LGBT people face frequent harassment and discrimination from young ages, leading to negative mental health outcomes and high rates of risk-taking that increase the likelihood of physical harm.

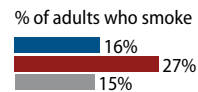
Impact of societal biases on engaging in risky behavior

■ Heterosexual ■ LGB ■ Transgender

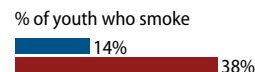
Health Disparity #15: LGB adults are more likely to have problems with alcoholism.¹⁹



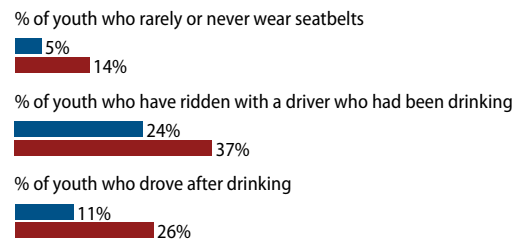
Health Disparity #16: LGB adults are more likely to smoke cigarettes.²⁰



Health Disparity #17: LGB youth are more likely to smoke cigarettes.²¹



Health Disparity #18: LGB youth are more likely to take risks in automobiles.²²



For example, the Family Acceptance Project’s research shows that “adverse, punitive, and traumatic reactions from parents and caregivers in response to their children’s LGB identity” is closely correlated with LGB youth having poor mental health and an increase in substance abuse.²⁵ To cope with stress and discrimination, some LGBT people turn to “self-medication,” resulting in higher rates of tobacco, drug, and alcohol use compared to the heterosexual population. Moreover, given that LGBT people often do not want to disclose their sexual orientation or gender identity in health care settings for fear of discrimination and provider bias, they are less likely to seek timely treatment.

Lack of competent care

Given the social stigma that leads members of the LGBT population to not disclose their minority status to health care providers, doctors and others are often unaware of their LGBT patients’ specific needs. This ignorance results in conditions going undiagnosed as well as doctors being unable to educate their patients about risky behaviors or other physical or mental health concerns. Furthermore, many LGBT people face outright hostility from their health care providers. One of the few existing studies of the transgender community shows that up to 39 percent of all transgender people face some type of harassment or discrimination when seeking routine health care.²⁶

Similarly, a general lack of data on LGBT people makes it difficult for doctors and other health care providers to learn about the LGBT population’s needs. This lack of information and data is reflected by the fact that most medical schools do not offer any coursework or instruction on the health needs of LGBT people. For example, researchers have found that over half of medical school curricula include no information about gay and lesbian people.²⁷ Programs in public health schools are also unlikely to include such information beyond work related to HIV/AIDS.²⁸

This exclusion from curricula and trainings matters: Students with exposure to lesbian, gay, bisexual, or transgender patients are more likely to perform more comprehensive patient histories, hold more positive attitudes toward LGBT patients, and possess greater knowledge of LGBT health care concerns.²⁹ All of these factors strongly contribute to better care and improved health outcomes for LGBT people.

This connection between training and actual practice—and the fact that many medical and health care students receive little exposure to LGBT issues—means that many doctors, nurses, therapists, and other health professionals are unable to meet the needs of LGBT patients. It is also highly unlikely that these caregivers create an atmosphere that makes LGBT people feel comfortable disclosing their sexual orientations or gender identities. Without a clear signal from a doctor or other health care professional that he or she is comfortable treating an LGBT person, for example by having “partner’s name” instead of

“spouse’s name” on intake forms, many members of the community will not feel safe “outing” themselves, leaving health care providers with inadequate information and preventing LGBT individuals from getting the treatment that they need.

We need more comprehensive data on LGBT health

Many of the data points shown earlier are from convenience samples of LGBT people in specific states or cities. Overall, current data and information on LGBT health can best be described as a loosely knit patchwork that often raises more questions than it answers. Fundamentally, despite the recent inclusion of sexual orientation and gender identity on a handful of state health surveys, significant gaps still exist in our knowledge of LGBT people’s health status and health care needs.

Experts note that much of the research to date on LGBT health issues has focused on sexually transmitted diseases, especially HIV/AIDS, and has neglected to study other health concerns, such as the importance of mammograms for lesbians or how high rates of harassment affect the mental health of LGBT youth.

Ulrike Boehmer’s analysis of the National Library of Medicine shows just how little health research exists on LGBT issues and populations: Boehmer examined the 3.8 million citations of articles in the National Library of Medicine published between 1980 and 1999, and found just 3,800 (0.1 percent) related to gay or transgender issues. Of these articles, 2,300 (61 percent) were disease-specific, with a focus on sexually transmitted diseases (mostly HIV/AIDS). Moreover, 80 percent of the LGBT articles focused on men, and 85 percent failed to include any mention of the racial or ethnic background of the individuals studied.³⁰

This disease-focused approach has resulted in “a lack of representative, population-based data that describes the full extent of LGBT people’s health experiences,”³¹ as well as a dearth of research on the resilience and positive health outcomes of LGBT individuals. To close these gaps, the University of California at San Francisco recommends that all health survey research include LGBT demographics.³²

This lack of research on the LGBT community is partially an outgrowth of the fact that no federal surveys collect information on sexual orientation or gender identity, including the National Health Interview Survey, which is the largest and most widely referenced federal health survey. The National Coalition for LGBT Health considers the NHIS the federal government’s “most comprehensive and influential” health survey, so the lack of LGBT inclusion is troubling.³³ California’s experience in developing, field testing, and analyzing a demographic question on sexual orientation could provide federal researchers with important lessons learned and other key feedback.

Concerns that respondents will not answer questions on sexual orientation and gender identity are unfounded. The testing of an LGBT demographic question to Centers for Disease Control and Prevention standards, for example, found that more people refuse to answer the income question (15 percent) than the sexual orientation and gender identity question (5 percent). In the Women Physician's Health Study, people were about as likely to not respond to questions about sexual orientation (4 percent) as they were to questions about alcohol consumption (3 percent) and gun ownership (3 percent), while nearly 20 percent would not answer questions about their income.³⁴ The National Coalition for LGBT Health found similar results in the Epidemiological Survey on Alcohol and Related Conditions and the Nurses Health Study II, concluding that “the refusal [to answer questions about sexual orientation and gender identity] has less to do with the topic and more to do with general unwillingness to answer any personal question.”³⁵

The Williams Institute at the UCLA School of Law recently released the final report of its five-year project on increasing the quantity and quality of available data on sexual minorities, including LGB people, people who identify as queer or same gender loving, and those who do not self-identify as nonheterosexual but who may have same-sex sexual partners. The report, “Best Practices for Asking Questions about Sexual Orientation on Surveys,” is aimed at researchers and policymakers and addresses issues that arise when questions on sexual orientation are added to demographic surveys, including health surveys. These issues include how to phrase questions to accurately capture responses from diverse populations, where to place them in the survey, and how to ensure statistical reliability of the resulting data.

While the report's main focus is sexual orientation, it includes a section on collecting data on transgender people. In addition to the fact that many sexual minorities may face discrimination on the basis of nonstandard gender identity or expression even if they do not identify as transgender, there is substantial overlap between the difficulties involved in measuring gender identity and those involved in surveying sexual orientation. Though much work remains to be done in overcoming these difficulties, the Williams Institute report is a major step forward in improving LGBT data collection methods.

Researchers at Brown University have tested survey questions on gender identity and report positive results. Their work includes suggestions for how other researchers can best ask these questions and shows promise for the development of data collection tools that can capture the full diversity of the LGBT community.³⁶

Despite the methodological concerns about asking questions on sexual orientation and gender identity, public and private health researchers should include them in their surveys to help collect more information on the health issues that impact LGBT people. A lack of regular, standard, and comprehensive data collection leaves the LGBT community with no tools to assess and measurably improve the health of its members. Improved data collection is necessary to establish a baseline against which future progress can be measured.

Recommendations

To start reducing the health disparities between LGBT people and the heterosexual population, the U.S. Department of Health and Human Services should establish a dedicated Office of LGBT Health. This office would take the lead in coordinating a consistent and scientifically driven response across HHS to LGBT health disparities.

The office should first request that any federally funded health study that collects demographic information on categories such as age, sex, race, ethnicity, primary language, or socioeconomic status should also include questions about sexual orientation and gender identity. HHS should appoint a panel of external and internal experts to advise its staff on how best to approach new survey questions on sexual orientation and gender identity. The methodological concerns we outlined earlier certainly need to be addressed, but they should not be used as a reason to not engage in this vital research and analysis.

Given the dearth of training and educational information on LGBT issues for health care students and professionals, HHS should also immediately prioritize cultural competency training for medical and nursing students and other relevant professionals. It should request that educational programs receiving HHS funding should incorporate LGBT cultural competency in their curricula. HHS should also work to make sure that any hospital, rehabilitation center, nursing home, or other facility receiving federal dollars implements a rigorous LGBT cultural competency training program for professional and nonprofessional staff.

Beyond a short-term focus on data collection and cultural competency training, the Office of LGBT Health at HHS needs a comprehensive long-term strategy to tackle the LGBT health concerns outlined in this report. Of critical importance is soliciting feedback from the LGBT community as this strategy is designed and implemented.

Finally, given the disproportionate number of LGBT people lacking health insurance, current efforts in Congress to expand coverage to more Americans would help reduce some of the disparities LGBT people face. The House-passed bill also included provisions related to LGBT health—for example, expanding the definition of “disparities populations” to include LGBT people. House and Senate leadership should work to maintain these provisions in the final bill that comes out of Congress.

Conclusion

As the rest of society moves toward a more comprehensive and supportive understanding of the LGBT population, the federal government needs to do the same. The U.S. Department of Health and Human Services should take the lead by treating this population the same way it does other minority demographic groups in our society. Devoting specific resources and attention to LGBT people will help improve—and even save—millions of lives.

Endnotes

- 1 See the Movement Advancement Project's "2009 Momentum Report" for an overview of public opinion data on LGBT issues as well as the rapid expansion of LGBT rights in the past decade. Available at <https://www.lgbtmap.org/momentum-report.html>
- 2 National Coalition for LGBT Health. *All of the Above: LGBT People of Color*.
- 3 Note that this paper uses the umbrella term "health disparities" to refer to disparities in health status and outcomes *and* health care access and quality.
- 4 Gary Gates "Same-sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey" (Los Angeles: The Williams Institute, 2006)
- 5 Figures represent the simple averages of coverage rates from multiple surveys and reports: Center for American Progress analysis of 2007 California Health Interview Survey data; Centers for Disease Control and Prevention. "Sexual Behavior and Selected Health Measures: Men and Women 15-44 Years of Age, United States 2002;" Movement Advancement Project, "Advancing Transgender Equality" (2009); Movement Advancement Project, "Outlook on LGBT Movement".
- 6 Center for American Progress analysis of 2007 California Health Interview Survey data.
- 7 Ibid.
- 8 Ibid.
- 9 Massachusetts Department of Public Health, "The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) Persons in Massachusetts" (2009).
- 10 Center for American Progress analysis of 2007 California Health Interview Survey data.
- 11 Ibid.
- 12 Massachusetts Department of Elementary and Secondary Education and Massachusetts Department of Public Health, "Health and Risk Behaviors of Massachusetts Youth, 2007" (2008).
- 13 Ibid.
- 14 Boulder County Public Health, "2003 Youth Risk Behavior Survey Boulder County" (2004).
- 15 Center for American Progress analysis of 2007 California Health Interview Survey data.
- 16 Ibid.
- 17 Figures represent the simple averages of suicide ideation rates from multiple surveys and reports: Movement Advancement Project, "Advancing Transgender Equality" (2009) and Massachusetts Department of Public Health, "The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) Persons in Massachusetts" (2009).
- 18 Figures represent the simple averages of suicide ideation rates from multiple surveys and reports: Boulder County Youth Risk Behavior Survey, 2003; Massachusetts Youth Risk Behavior Survey, 2007; Washington, DC Youth Risk Behavior Survey, 2007.
- 19 Figures represent the simple averages of alcohol abuse rates from multiple surveys and reports: Movement Advancement Project, "Advancing Transgender Equality" (2009) and Center for American Progress analysis of 2007 California Health Interview Survey data.
- 20 Figures represent the simple averages of smoking rates from multiple surveys and reports: Center for American Progress analysis of 2005 California Health Interview Survey data and Massachusetts Department of Public Health, "The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) Persons in Massachusetts" (2009).
- 21 Figures represent the simple averages of smoking rates from multiple surveys and reports: Boulder County Youth Risk Behavior Survey, 2003 and Massachusetts Youth Risk Behavior Survey, 2007.
- 22 *Boulder County Youth Risk Behavior Survey*, 2003.
- 23 Vickie Mays and Susan Cochran, "Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States." *American Journal of Public Health* 91 (11) (2001): 1869-1876.
- 24 Michael Ash and Lee Badgett, "Separate and Unequal: The Effect of Unequal Access to Employment-based Health Insurance on Same-Sex and Unmarried Different-Sex Couples," *Contemporary Economic Policy* 24 (4) (2006): 582-599.
- 25 Caitlin Ryan and others, "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults," *Pediatrics* 23 (1) (2009): 346-352.
- 26 Movement Advancement Project, "Advancing Transgender Equality" (2009).
- 27 Catherine Tesar and Susan Rovi, "Survey on Curriculum on Homosexuality/ Bisexuality in Departments of Family Medicine," *Family Medicine* 30 (4) (1998): 283-287.
- 28 Heather L. Corliss, Michael D. Shankle, and Matthew B. Moyer, "Research, Curricula, and Resources Related to Lesbian, Gay, Bisexual, and Transgender Health in U.S. Schools of Public Health." *American Journal of Public Health* 97 (6) (2007):1023-1027.
- 29 Nelson Sanchez and others, "Medical Students' Ability to Care for LGBT Patients." *Family Medicine* 38 (1) (2006): 21-27.
- 30 Ulrike Boehmer, "Twenty Years of Public Health Research: Inclusion of Lesbian, Gay, Bisexual, and Transgender Populations," *American Journal of Public Health* 92 (7) (2002): 1125-1130.
- 31 Ibid.
- 32 University of California San Francisco. "The Importance of Sexual Orientation and Gender Identity in Health Research" (2008).
- 33 National Coalition for LGBT Health. "LGBT Inclusion in Federal Health Surveys." Undated.
- 34 Donna Brogan and others, "Methodologic Concerns in Defining Lesbian for Health Research." *Epidemiology* 12 (1) (2001): 109-113.
- 35 National Coalition for LGBT Health, "LGBT Inclusion in Federal Health Surveys." Undated.
- 36 Senseman Scout, "Cognitive Testing of an LGBT Surveillance Question," (Boston: LGBT Tobacco Control Network, 2008).