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Countering Disparities in Health Care for Sexual Minority Women

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Health disparities – differences in the health status of different groups of people – do not simply occur by chance. Instead, they result from interactions among many factors, including public policies, access to resources, cultural beliefs influencing medical care, individual behaviors, and genetics. Because health patterns have complicated sources, solutions to disparities in healthcare access and outcomes are rarely simple.

Despite increased acceptance over the past few decades, studies consistently find health difficulties disproportionately affecting lesbian, gay, bisexual and transgender people. Inadequate use of care is a contributing factor to these health disparities, particularly among sexual minority women – that is, women who are lesbian, bisexual, queer, or identify as something other than heterosexual. Although same-sex marriage is now legal in every state, allowing for health insurance benefits to be extended to same-sex spouses, expansion of full rights to sexual minorities is not occurring uniformly across the country. Only 20 states have laws protecting sexual and gender minority individuals against discrimination.

Discrimination not only persists; it harms health outcomes. In contrast to heterosexual women, sexual minority women are more likely to delay care and less likely to seek preventative care, in part because minority women report negative experiences with their providers.

Barriers to Care at Both Provider and Policy Levels

My recent work with colleagues explored interactions between sexual minority women and their healthcare providers to identify obstacles to the delivery of good care. We found that providers who simply assume that patients are heterosexual may not interact effectively with patients who are not – yet that sort of assumption is often made when patients are seeking health care for sexual or reproductive issues. Frequently, female patients are asked “are you sexually active,” and then “are you on birth control?” A “yes” to the first question and a “no” to the second lead providers to assume that these women are engaged in unprotected penile-vaginal intercourse and thus are at risk for pregnancy. Providers may regard these patients as irresponsible for not reporting contraception use, and, as study participants put it, lecture them about birth control. For many sexual minority women, obviously, this scenario based on false assumptions simply misses the point and leads to failed communications.

More than half of sexual minority women participants in our study had not been asked about their sexual orientation, either on intake forms, by office staff, or by their providers directly. This matters not only because having such information can head off mistaken assumptions, but because disclosure of sexual identity is related to better healthcare outcomes and improved satisfaction with care. Additional kinds of negative interactions, we found, happened when providers failed to understand the kinds of health needs typically experienced by sexual minority women, and in unfortunate instances – happily rare – when providers made phobic comments to patients (for example, declaring that the patient needed to be treated for same-sex attraction).

Beyond what directly happens in interactions, the external environment in which people seek and receive care also matters. Factors such as state legislation can either facilitate good care or create barriers. Cultural assumptions are often at work, specifically the idea that heterosexuality is the norm and the unquestioned assumption that everyone is – or should be – heterosexual. Such assumptions and beliefs affect patients, providers, and policymakers alike, influencing use of health care and sustaining health disparities that hurt sexual minority women. In another study, my colleagues and I found that sexual minority women living in states that do not have laws prohibiting discrimination against gay, lesbian, and other sexual minority individuals reported lower satisfaction with their healthcare providers. In contrast, protective legislation was

positively associated with patient satisfaction in those states. Greater patient satisfaction, in turn, is linked to increased health care use.

Ways to Reduce Health Care Failures Affecting Sexual Minority Women

Our findings highlight the need to address both the interpersonal factors inhibiting health care use and the sociopolitical environment in which individuals seek and receive care.

A basic step is for healthcare providers to encourage identity disclosure. The very act of providers asking patients questions about sexual history or identity can show provider openness to various forms of sexuality. Language used to ask should be inclusive and gender-neutral (for example, asking about spouses or partners). Questions can be posed on patient intake forms or initiated in conversations by providers. An exception arises when there is a chance that patient disclosures could be greeted with bias by anyone on staff.

Patient experiences with discriminatory treatment underline how important it is for medical education to acknowledge and take steps to prevent bias. The specific healthcare needs of sexual minorities must be included in general medical curricula, and due attention paid to the fact that such patients more frequently disclose their sexuality during visits related to sexual or reproductive health. Unfortunately, as cost-conscious managed-care spreads, clinician-patient relationships can be undermined unless providers have the time and autonomy they need to deliver good care.

Currently, 30 states do not extend protections against discrimination based on sexual orientation or gender identity. Because the external environment in which patients seek care is related to the quality of care they get, medical and public health communities have a vested interest in supporting basic rights for all. For-profit healthcare networks also share this interest, because policies that ensure equal rights may reduce healthcare costs.

Read more in Aleta Baldwin, Brian Dodge, Vanessa Schick, Debra Herbenick, Stephanie A. Sanders, Roshni Dhoot, and J. Dennis Fortenberry, "Health and Identity-Related Interactions between Lesbian, Bisexual, Queer and Pansexual Women and Their Health Care Providers." *Culture, Health & Sexuality* (2017): 1-16; and Aleta Baldwin, Brian Dodge, Vanessa Schick, Stephanie A. Sanders, and J. Dennis Fortenberry, "Sexual Minority Women's Satisfaction with Health Care Providers and State-Level Structural Support: Investigating the Impact of Lesbian, Gay, Bisexual, and Transgender Nondiscrimination Legislation." *Women's Health Issues* (2017).