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Lesbian, Gay, Bisexual, and Transgender Health Disparities, and President Obama's Commitment for Change in Health Care*

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Abstract: Health care services in America are evolving. However, the state of sexual minority health is fraught with individual and institutional health disparities. The Obama Administration and other health organizations are beginning to develop the infrastructure needed to provide quality medical care to all Americans including sexual minorities. In this paper, we review the current state of health for sexual minorities including prevalent health disparities, access to quality care, communication, disclosure, current health issues and disparities. Finally, we will discuss the Obama Administration's role, and how medical and public health professionals can assist through better data collection, health communications, and service delivery for lesbian, gay, bisexual and transgender people. A reduction in health disparities will benefit all Americans.

Keywords: gender; sexual minorities; health disparities

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"Social stigma and systematic discrimination based on sexual orientation and gender identity and expression have led to decades of obstructed access to adequate LGBT affirmative and culturally competent health care..."
~~Rebecca Fox and Kellan Baker, National Coalition for LGBT Health

"Biology loves variation. Society hates it."
~~Dr. Milton Diamond

"The category of sex is the political category that founds society as heterosexual."
~~Monique Wittig

Health care in America is evolving. There are millions of people in America who do not have access to optimal health care. A multitude of factors impact American's opportunities for access to quality health care including race/ethnicity, gender/sex, education, class, age, and religion. As a nation we should be concerned and work toward equal access to health care for all. During the last presidential election, it was reported that President Obama received the support of many members and supporters of the lesbian, gay, bisexual, and transgender (LGBT) community. President Obama was sworn in as President on January 9, 2009, and the LGBT community awaits improvement in health care. The following bill H. R. 3001 was first introduced to

the 111th Congress, June 23, 2009, and President Obama had been in office a little more than four months. The bill states:

> To address the health disparities experienced by lesbian, gay, bisexual, and transgender Americans, to eliminate the barriers they face in accessing quality health care, and to ensure that good health and well-being is accessible to all. The bill is sponsored by Tammy Baldwin, a Democrat in Wisconsin (H.R. 3001—111th Congress: Ending LGBT Health Disparities Act, 2009).

This bill is the first step in the legislative process. Bills and resolutions that are introduced, first go to committees that deliberate, investigate, and revise them before they are considered for general debate. The majority of bills and resolutions never make it out of committee. The latest action on bill H.R. 3001 was recorded on August 3, 2009: when the House Armed Services Committee referred the bill to the Subcommittee on Military Personnel (H.R. 3001—111th Congress: Ending LGBT Health Disparities Act, 2009). President Obama, the American people, and LGBT community are facing challenges in their efforts to achieve better health care for all in the United States, and the referral of this bill serves as a prime example.

In this paper, we will focus on the current state of health care for the LGBT community, and President Obama's challenges toward that result. The health of LGBT people, sometimes referred to as sexual or gender minorities, has emerged as a national health concern because of the documented health disparities to which these populations are exposed to and at risk for. Health disparities can be defined as differences in incidence, prevalence, mortality, and burden of diseases and other health conditions among specific populations (Donatelle, 2010:171).

THE ISSUES

Sex has always been a controversial topic, and gender is as well, although the term gender is not well understood in our society. The terms sex and gender are sometimes used interchangeably which blurs the health issues at hand. Sex is biological; it is what we are labeled at birth, based on sexual appearance. People are generally labeled as female, male, or intersex. Gender is social construct, it is what we become though our being, personality development, culture, and environment. Gender is who a person becomes through their socialization process and development.

> Sexual [orientation] and gender identity are characterized by fluidity and change, as many individuals who report same-sex behavior identify as heterosexual and others consider themselves to be alternately heterosexual, bisexual, and/or homosexual (or some other variation in pattern), as self-perception changes over time. (Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008).

Society sets standards to regulate sexual behavior. Sex is important because it is connected to power. Therefore, a culture and/or society will define acceptable and unacceptable sexual conduct to mandate normal from abnormal behavior (Donatelle, 2010). Kelly (as cited in Donatelle, 2010) wrote one of the common sociocultural standards for acceptable sexual behavior in Western culture today is "the coital standard, which means penile-vaginal intercourse (coitus), is viewed as the ultimate sex act" (Donatelle, 2010:182).

The standard above may be considered ideal for some in our culture, but others in our diverse society are left out altogether, and this is where the health disparities arise. Gender bias is pervasive. From the time we are conceived our biological parents may be contemplating whether we will be born as a male, female, or intersex. Medical care begins at birth with weighing, measuring, APGAR scores, often times circumcision for males, and likely we are clothed in pink or blue, depending on our biological label. And so it begins; we are examined and labeled, but it doesn't end there.

> The models further distinguish the differences between sex (the objective categorization of one's biology as male, female, or intersex), sexual orientation (whom on is attracted to), gender identity (a subjective sense of oneself as male, female, or other), gender role (cultural expectations that one follow a set of prescribed behavioral norms based on one's gender), gender presentation (how one looks) (Feldman as cited in Makadon et al., 2008:333), gender performance (how one acts) (Feldman as cited in Makadon, et al., 2008:333), gender assignment(gender that is assigned by birth by a medical provider (Bornstein as cited in Makadon et al., 2008:333), usually based on appearance of the external genitalia), and gender attribution (attribution of one's person gender by another, based on cultural interpretation of gender cues. (Bornstein as cited in Makadon et al., 2008:333).

Friends will ask, so what did you have, a girl, boy, or intersex? We will likely respond with a girl or a boy. Intersex babies might not be talked about until the parents decide what to do, but that is another topic. Our biological sex is of most importance to parents-to-be in our society. People do not think about gender, do not contemplate whether their child will be born lesbian, gay, bisexual, queer, or transgender. That statement is very telling and informs us of where gender ranks in importance in our society. We all know that our sex is biological, and that our gender is socially constructed by our culture, environment and experiences. Many forces act upon our being to form our gender. Your friends will not likely ask, so what did you have, a lesbian, gay, bisexual, or transgender child. And that is okay because that label or determination may not surface until later in the child's development, but the point is clear. We expect a sex, but we do not consider the

variations in gender, and we assume heterosexual.

If people are not heterosexual there is a higher probability that they will be discriminated against, and this happens for many reasons. Quality of care and access is affected because people are less likely to disclose a sexual identity other than heterosexual. This reflects the continuing existence of homophobia and transphobia (Auerbach, 2008). Partially, this problem has to do with the intake or new patient forms that patients are asked to complete when they have an appointment in a medical facility. Most of our data collection surveys and questionnaires ask us to check male or female; sexual orientation and gender identity questions are generally not asked in public health or clinical settings (Sell & Becker, 2001; Auerbach, 2008), but they are an important component of health and health care. Another barrier to quality and access to care has to do with education. Clinicians and practitioners do not know the numbers of LGBT people they serve since data is not often collected. This perpetuates the cycle of transphobia and homophobia, and a type of "don't ask don't tell" is predominant in clinical settings. The questions about gender identity are not options on intake and new patient forms. This is likely to cause many patients to feel uncomfortable about disclosing their gender identity, and this adds to the continuing issue of health disparities.

If an LGBT person is required to fill out a form that does not have a category that describes their sexuality it could impact their mental health, self-concept and esteem, as well as overall health because they would feel as an "other". This should remind us of US Census surveys where until recently categories were not inclusive for race and gender. "Othering" refers to the process that "magnifies and enforces projections of apparent difference," which "reinforce and reproduce positions of domination and subordination," often leading to experiences of "marginalization, decreased opportunities and exclusion" (Johnson, Bottorff, Browne, Grewal, Hilton, & Clarke, 2004:254).

If intake forms included categories for diverse gender identities, and providers were trained and educated to provide culturally competent care, and were educated about the range of public health issues that affect the LGBT community then disclosure of sexual orientation and gender identity would likely reduce the percentage of existing health disparities. At this time most professional schools and continuing education programs do not provide the education necessary to improve practitioners' cultural competency skills and diverse gender identity training to attend to the health of LGBT patients (Makadon, 2006; Tesar & Rovi, 1998; Mayer et al., 2008).

Communication and disclosure are significant issues that also need to be addressed. LGBT clients and patients are more likely to remain silent about important health issues because they fear disclosure may lead to judgment, individual or institutional discrimination, and stigmatization (Dube, 2001; Bockting, Robinson, & Rosser, 1998; Schatz & O'Hanlan, 1994; Bradford & Ryan, 1988). Cole, Kemeny, Taylor, and Visscher (1996) conducted a study in psychoneuroimmunology and found a direct association between psychological phenomena, lowered immunity, and the growth of tumors. They concluded that LGBT persons who do not disclose their sexual orientation may be at a higher risk for cancers because of psychogenic suppression of the immune response (Cole, Kemeny, Taylor, & Visscher, 1996). Some strategies that have been suggested to encourage both communication and disclosure are to create a clinical climate that provides signals to patients that the facility is a safe place to talk about sexual orientation and gender identity. Medical facility employees could be required to have cultural competency training, to speak to all patients and clients in a non-judgmental gender appropriate manner. These techniques could be a component of a professional education curriculum (Gay and Lesbian Medical Association, 2007; Mayer et al., 2008).

Effective communication is essential to quality medical care. The intake forms could include questions that have appropriate responses for gender identity, sexual orientation, and same sex partners as well as other sex partners. Office literature and brochures could include LGBT pamphlets about reproductive issues, health promotions and risks (Mayer et al., 2008). The benefit of this culturally competent climate is far-reaching. The staff, the clients and patients, heterosexual as well as patients of other genders and sexual orientations would all become exposed to the culturally competent climate, and would this not cause more acceptances of difference and diversity?

These practices could go a long way toward reducing individual and institutional discrimination, health disparities, and promoting effective communication and disclosure. This is important because LGBT people are at risk for a multitude of health problems including, substance use and abuse, violence and bullying, cancer, heart disease, tuberculosis, obesity, and other lifestyle behavioral choices (Koh, 2000; Aaron, Markovic, Danielson, Janosky, & Schmidt, 2001).

Health Issues

Following is brief summary of some of the physical issues of which sexual minorities are at risk.Lesbians are defined as women who are attracted to and have sexual relationships with women. It has been reported that lesbians are at a higher risk for certain cancers, such as breast, cervical, ovarian, and endometrial (Cochran et al, 2001). This is suggested because they typically have fewer pregnancies, less frequent use of oral contraceptives, increased risk of obesity, increased use of alcohol and tobacco (Koh, 2000). Lesbians also, reportedly, have increased risks for sexually transmitted diseases (STD), including HIV/AIDS (Dube, 2001; Koh, Gomez, Shade, & Rowley, 2005). Risks of female to female transmission remain under-researched, although most HIV+ women report having both male and female

sexual partners at some time during their sexual lives (Dean et al., 2000; Diamant, Wold, Spritzer, & Gelberg, 2000; Dube, 2001).

The reasons stated for the cancer risks were delayed diagnosis; the interval between pap smears was up to three times longer for lesbians than for heterosexual women (Koh, 2000; Koh, Gomez, Shade, & Rowley, 2005). Many lesbians and physicians wrongly assume lesbians are at a lower risk (Cochran et al, 2001). However, many lesbians have had sexual intercourse with a male at some point during their lives and some continue to do so at irregular intervals. Also, the Human Papillomavirus (HPV) can be transmitted by sharing sex toys with an infected partner, if there is not proper cleaning between uses (Dean et al., 2000; Dube, 2001; Makadon, Mayer, Potter, & Goldhammer, 2008).

Lesbian sex can transmit most STDs. It is important to screen lesbian and bisexual women on the same recommended schedule as heterosexual women. Physicians will ask often women how many men they've been with, but not assess for women who have sex with women (WSW). Common vaginal infections can also be spread during woman to woman sexual contact. These include yeast, trichomonas and non-specific bacterial vaginosis (Dube, 2001; Dean et al., 2000; US Department of Health and human Services, 2000; Healthy People 2010, 2001).

Reproductive health needs should be discussed outside implied heterosexual activity. Fertility assistance is possible for same sex couples. For example, one woman could have her eggs harvested, inseminated, and the resulting embryo(s) could be implanted in her partner's uterus, so that both women were biological parents. Seeking a court's validation of both women as legal and custodial parents is advisable (Dean et al., 2000).

In Dilley's (2010) study it was found that both lesbian and bisexual women were more likely to have asthma than were heterosexual women. Interestingly, lesbian and bisexual women had higher odds for overweight and heavy drinking and smoking than did heterosexual women (Gruskin, Hart, Gordon, & Ackerson, 2001; Hughes & Jacobson, 2003; Tang, Greenwood, Cowling, Lloyd, Roeseler, & Bal, 2004; Dilley et al, 2005; Gruskin & Gordon, 2006; Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007). However, women had similar odds for insufficient physical activity, and a low intake of fruits and vegetables, regardless of sexual orientation (Aaron et al., 2001; Cochran & Mays, 2007; Dilley, Simmons, Boysum, Pizacani & Stark, 2010).

Gay men are generally referred to as men who are attracted to and have intimate relationships with men. Studies have found that gay and bisexual men are at an increased risk for anal cancer, non-Hodgkin's lymphoma, and Hodgkin's disease (Dube, 2001; Dean et al., 2000). Although the authors determined that the increase in risk for both non-Hodgkin's lymphoma and Hodgkin's disease was related to increased incidence of HIV/AIDS among gay men, they found the

increased risk for anal cancer to be unrelated to Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) (Koblin, Hessol, Zauber, Taylor, Buchbinder, Katz, & Stevens, 1996; Dube, 2001).

Gay men are at a higher risk for HIV/AIDS related cancers, for example, Kaposi's Sarcoma (KS), caused by HHV-8 (Human Herpes Virus), Non-Hodgkin's Lymphoma, increased incidence and association with HIV +, HIV+ men are more at risk because: Immuno-compromised patients have a higher incidence of cancer. Decreased CD-4 count has been associated with increased progression to cancer (Dube, 2001; Dean et al., 2000).

Physical attractiveness is important to gay men; they want to be attractive to other men. Eating disorders (Carlat, Camargo, & Herzog, 1997) and body image dissatisfaction (Beren, Hayden, Wilfley, & Grilo, 1997) is more common among gay men than heterosexual men. There are screening tools available for eating disorders (Makadon, Mayer, Potter, & Goldhammer, 2008).

HIV continues to have a profound effect both physically and psychologically on this subpopulation (Cochran & Mays, 2007). Youth represent a subgroup of gay men who are particularly likely to engage in high-risk behavior, and so are particularly at risk for HIV. CDC (2006) identified youth (ages 13-24) as the single most likely group to contract STDs, with 34% of new HIV infections reported as MSM (CDC, 2006). There is a significantly higher percentage of African American and Latino youth being infected with HIV than white youth (CDC, 2006).

There is a limited amount of research available to aid in our understanding of the needs of bisexuals (Oswalt, 2009). Bisexual individuals may experience more discrimination than lesbians and gays. Biphobia, or the fear or hatred of bisexual people, is distinct from homophobia in that bisexual individuals experience dual marginalization—discrimination from both the heterosexual and gay/lesbian communities (Ochs, 1996). Firestein and Green (2007) defined bisexual as one's erotic, emotional, and sexual attraction to persons of more than one gender. Such individuals may identify as bisexual, homosexual, lesbian, gay, heterosexual, transgendered, or transsexual or may choose not to label at all (Firestein & Green, 2007). In addition to discrimination, some people insist that people are either heterosexual or homosexual, and that there is no in-between. This bi-invisibility can undermine a bisexual person's sense of self and contribute to poor health and support systems.

Bisexuals face special identity challenges because most research does not separate bisexual men from gay men or bisexual women from lesbians (Dobinson, MacDonnell, Hampson, Clipsham, & Chow, 2005). Bisexuals are different from gays and lesbians, and difference does not equal disorder. Bisexuals have the right to be identified and researched as bisexuals. A few studies have been conducted

on males and females who identified as bisexuals and they found that bisexual men and women have higher levels of anxiety, depression, suicidality, negative affect (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002) and self-injurious behavior (Balsam, Beauchaine, Mickey, & Rothblum, 2005) than do other sexual orientation groups (Cochran & Mays, 2007). Specifically, bisexual men and women "experienced more current adverse life events, greater childhood adversity, less positive support from family and more negative support from friends" (Jorm et al., 2003) than did heterosexual individuals, gay men and lesbians (Oswalt, 2009).

Regarding bisexual women and their overall physical health, according to the few studies that exist, they are reported to have higher rates of overweight and obesity than do heterosexual women, but not as high as lesbians (Diamant & Wold; 2003; Case, Austin, Hunter, Manson, Malspeis, Willett, & Spiegelman, 2004; Valanis, Bowen, Bassford, Whitlock, Charney, & Carter, 2000). Bisexual women, like lesbians, have higher risks for breast cancer when compared to heterosexual women; lower rates of pregnancy; are more likely to give birth after age 30, and have higher rates of tobacco and alcohol consumption. Studies showed various rates for screening behaviors (Koh, 2000; Case et al., 2004; Valanis et al., 2000; Miller, Andre, Ebin, & Bessonova, 2007; Koh, Gomez, Shade, & Rowley, 2005). In a recent study, Dilley et.al., (2010) reported that bisexual women had about double the odds for diabetes and also increased odds for hypertension compared with heterosexual women (Dilley et al., 2010).

Existing studies comparing bisexual men from gay men in regard to their physical health are absent from the literature (Miller et al., 2007). Practitioners should be aware that that some bisexual men may experience body image issues similar to gay men, that could lead to compulsive exercising, steroid use, poor body image, and eating disorders (Miller et al.,2007).

The simple definition of a transgender person is having a gender identity that does not match one's visual biological sex (Donatelle, 2010). It is more complex than that because some see transgender as a "gender identity disorder" (GID). Gender identity disorder is a diagnosis defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, 2000) which describes persons who have strong and persistent cross-gender feelings. The diagnosis is helpful toward identifying individuals who are appropriate for clinical interventions to improve their adjustment to their sexuality (Makadon, et al., 2008). Whether or not it is a true disorder depends on the individual. Basically, a person who is born biologically male may feel and identify as a female, and a person who is born biologically female may feel and identify as a male. The same could be true of a person born as an intersexual (having both male and female secondary sex characteristics).

Transgender persons face a myriad of health care issues. Transgender persons are feared (transphobia) and discriminated against in many segments of our

culture. Oftentimes, their basic health care and support systems are lacking. If they are "out" they are at a higher risk for unemployment and underemployment, homelessness, substance use, HIV, anxiety, depression, suicide, self-harm, sex work, and hate crimes (Makadon et al., 2008). Some transgender people do not suffer from GID and some do not desire to change their appearance. A primary concern is whether or not they decide to have surgery to create a physical body that better aligns with their psychological identity. These may include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males, and surgery.

Guidelines are available for the psychiatric, psychological, medical and surgical management of gender dysphoric persons. The guidelines also include information for people who want hormone therapy or surgery to change their appearance. The Harry Benjamin Standards of Care (SOC) are available at http://www.wpath.org (Makadon et al., 2008).

Transgender people are at higher risks for cancers of the reproductive type because if they transition through surgery their organs of birth are not removed. Therefore they are at risk for a great numbers of cancers. Also, hormone therapy puts transgender people at a higher risk of cancers associated with hormones (Dean et al., 2000; Dube, 2001).

As a nation we have many challenges addressing mental health issues in the general population. Those issues have far reaching effects for sexual minorities. Sexual minorities face individual and institutional discrimination which put them at a higher risk for mental health challenges. The degree varies with the individual. The literature informs us that sexual minorities use more alcohol and tobacco than the general population. Many times substance use is a way of self-medicating. Of course, more substance use is associated with a higher risk of health problems. Sexual minorities have many challenges to their mental health. They may suffer negative social climates, increased exposure to stressors, misleading portrayals, stereotyping, negative interactions with neighbors, colleagues, friends and families.

Sexual minorities are at a higher risk for depression, panic and mood disorders, and anxiety. Hatzenbuehler, McLaughlin, Keyes, and Hasin (2010) published a study about the impact of institutional discrimination. Institutional discrimination is when some institutional organization, like a government, promotes discrimination (Hatzenbuehler et al., 2010). Examples provided in the article are bans on gay marriage and employment discrimination based on sexual orientation. Institutional discriminations are societal level conditions that constrain the opportunities, resources, and well-being of subpopulations of society (Link & Phelan, 2001). Sexual minorities residing in states that uphold discriminatory policies are at a higher risk for serious mental health consequences (Hatzenbuehler et al., 2010).

Sexual minorities are at a greater risk for hate crimes, suicide attempts, and domestic violence (DV). Physicians often do not screen same sex couples for DV. Estimated rates are similar in homo and heterosexual couples (Makadon et al., 2008).

Possible Solutions and Conclusions

The above information regarding the health issues that LGBT people face is just a brief thumbnail description. It is certainly clear that there are plenty of barriers to optimal health among the members of sexual minorities. What can be done?

The Institute of Medicine (IOM) has recommended that educational opportunities be expanded to increase public health practitioners' knowledge of sexual minority health issues. They have a long laundry list of critical issues of regarding LGBT health issues which include: state of knowledge regarding LGBT health status, health risks, health disparities, and access and utilization of health care; developmental process of childhood and adolescence, in the context of the family; impact of the family and social acceptance of sexual orientation on mental health and personal safety; the effects of race, age, ethnicity, and geography (urban versus rural); assessing methodological challenges, definition and measurement issues, study design issues involved in conducting research; research gaps and opportunities, study design, and identification of best practices; and research training needs that might be impeding the advancement of knowledge about LGBT health (Institute of Medicine, 2010). Other organizations such as the American Public Health Association and the American Medical Association, among others have similar laundry lists.

There has been progress in the past couple of decades. Free standing clinics have been opened and the necessary infrastructure is improving and growing. Some state health departments have created staff positions or offices to address the health of the LGBT community (Auerbach, 2008). The Institute of Medicine (IOM) published a report on the state of health for lesbians; the Gay and Lesbian Medical Association, The Human Rights Campaign, and the National Gay and Lesbian Task Force and many other organizations have joined forces to address the health of sexual minorities using systematic strategies (Mayer et al., 2008). An LGBT companion document to the Healthy People 2010 initiative identified 29 specific objectives that prioritized sexual minorities, but data by sexual orientation were not available in public health surveillance systems to track most of those objectives (Dilley, 2010). Progress is slow, and until there is a greater foundation and stronger infrastructure to apply for and administer peer-reviewed reviewed population-based grants from the National institutes of Health and the Centers for Disease Control and Prevention to proficiently research LGBT health issues our data numbers will be inaccurate and misleading (Auerbach, 2008; Mayer et al., 2008).

April 15, 2010, President Obama issued a memorandum to the Department of Health and Human Services (HHS) instructing relevant agency administrators and staff to develop a protocol to ensure that individuals are not discriminated against in medical settings on the basis of sexual orientation or gender identity. The memorandum requested the protocol be implemented to protect LGBT patients and their families, and address the issues of hospital visitation, medical decision-making, and other current health care issues that cause individual and institutional discrimination (Obama, 2010). It is one more step in the right direction toward optimal health care for all. However, H. R. 3001 is still, as of this writing, in the Subcommittee on Military Personnel.

Earlier it was stated that a multitude of factors impact American's opportunities for access to quality health care including race/ethnicity, gender/sex, education, class, age, and religion. In our country it seems that there is a cumulative effect. The more of these factors an individual possesses, if the factor is considered different or not the societal "norm", the higher the risk for health disparities. President Obama, his administration and the American people have a lot of work and collaborating to do to assure optimal health care for all. When subpopulations are denied what others have, it affects the health of all, and the state of sexual minority health is fraught with individual and institutional health disparities.

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