LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, ASEXUAL, INTERSEX ET AL. (LGBTQAI+) HEALTH ACCESS DISPARITIES IN FEMALE-IDENTIFIED CLIENTS

JENNIFER HAND

Though they recently received legal legitimacy, the LGBTQAI+ community faces discrimination through deeply entrenched heterosexist social systems, which amplify inequities for women and gender minorities. Social workers must advocate for expansive policy interventions to promote economic and health equity for female-identified members of the LGBTQAI+ community. Practical policy interventions for the promotion of health equity include provider training programs, anti-discrimination protections, the collection of comprehensive demographic data, and youth education curricula.

INTRODUCTION: CODIFYING BASIC RIGHTS

To address lesbian, gay, bisexual, transgender, queer, asexual, intersex et al. (LGBTQAI+) health policy, we must consider the historical context of the population in the United States.[1] Within the last twenty years, the legal system codified basic safety and fundamental rights for LGBTQAI+ citizens. The legal system makes change slower than most other systems in order to preserve the rule of law from the tidal waves of popular opinion, and law often follows and codifies established policy. In the United States, there is great discrepancy in social attitudes towards this community that the creation of anti-discrimination laws beget new policies across all areas of social systems (Harrison & Michelson, 2017). Consequently, new anti-discrimination laws prescribe the conscientious and meticulous undoing of systemic bias in all of our social services, from housing to health care.

According to Martos, Wilson, & Meyer (2017), LGBTQAI+ health care was born out of self-advocacy and self-determination from the beginning. In the mid-20th century, underground LGBTQAI+ activism groups began emerging, effectively birthing identity politics for the community (Martos et al., 2017). After the Compton's Cafeteria Riot in San Francisco in 1966 and the more widely known Stonewall Riot in 1969, during which the police raided queer spaces to humiliate and criminalize the community, organizers

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[1] Until *Obergefell v. Hodges* (2015), the community was denied the right to marriage. This decision is significant in that the right to marriage is not the right to love unencumbered, but the right to retain financial and other benefits through the formation of a legally recognized partnership. Until *Lawrence v. Texas* (2003), the United States criminalized sex acts between two consenting adults. Again, this case illuminated the legal discrimination against a marginalized group and attempted to protect the community from government intrusion into personal affairs. Lastly, *Romer v. Evans* (1996) was the first federal case law protecting the LGBTQAI+ community from state-sanctioned "bare animus"—the intent to harm a politically unpopular group.

mobilized to carve out intentional queer spaces including community-based health organizations—in urban centers around the country.

Following these advocacy efforts and the removal of homosexuality from the DSM in 1973, care centers focused on LGBTQAI+ health emerged en masse in the 1970s (Martos et al., 2017).[2] Due to rampant homophobia and transphobia among the medical and other care professions, the standard of care for LGBTQAI+ individuals was low, to the point where individuals would not feel comfortable disclosing lifestyle and health habits to providers for fear of discrimination. As a person's lifestyle intersects very closely with his or her health care provision and health outcomes, this is an unacceptable discrepancy. This hesitancy to discuss care with providers due to stigmatization—and thus harm reduction practices—may indeed be a key reason the HIV epidemic decimated this population in the 1980s and 1990s (King, 2011).[3]

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Nearly fifty years after the riots sparking organizing efforts, and about twenty years after the initial case law identified them as an "unpopular political group" (*Romer v. Evans*, 1996), the LGBTQAI+ community continues to work aggressively towards undoing homophobia, transphobia, biphobia, heterosexism, and sexism in every area of social services. As LGBTQAI+ service provision is still an emerging area of law, policy, and health care for a high needs population, service delivery has much room for improvement (Martos et al., 2017).

LGBTQAI+ DISPARITIES IN HEALTH ACCESS

As heterosexism, homophobia, transphobia, biphobia, and misogyny become less overtly enacted on LGBTQAI+ identified individuals due to statutory intervention,[4] members of the community still experience

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[2] At the same time, Gender Identity Disorder was codified in the DSM and opened the transgender community up to discriminatory medical practices (Martos et al.).

[3] Discussion of the HIV epidemic and its impact on LGBTQAI+ health policy with due diligence would require more words than permitted by this submission and is not entirely germane to the subject matter of SMW health disparities.

[4] On September 29, 2017, the United States voted against a ban on the death penalty for same-sex relations at a United Nations conference. Similarly, the United States Department of Justice filed an amicus brief—legal support which may influence case law—for *Masterpiece Cakeshop v. Civil Rights* Commission on September 6, 2017. This case is before the Supreme Court of the United States regarding the tension between first amendment rights of business owners and legal discrimination against the LGBTQAI+ community in the contracting of

structural inequities, which may limit their quality of life and cause long-term damage to their well-being (Eckstrand, Lunn, & Yehia, 2017). LGBTQAI+ populations experience higher barriers to healthcare than heterosexual populations (Eckstrand et al., 2017). The population also experiences an "increased incidence of sexually transmitted infections, mood and anxiety disorders, and intimate partner violence" as compared to heterosexual and cisgender populations and experiences poorer health outcomes across the lifespan (Lunn et al., 2017).

Lunn (2017) estimates that 2.4% of the general population is LGBTQAI+ identified and represents a cross-section of the general population. Though already disadvantaged, the community—due to its diversity across age, gender, socioeconomic status, ethnicity, and race—reflects the systemic inequities prevalent in the greater population (Krehely, 2009). Minority stress, often linked to poor health outcomes due to internalization of isms and externalized discrimination, is intensely compressed in these populations (Mule et al., 2009). Notably, LGBTQAI+ individuals of color are simultaneously pathologized as disease-carriers yet denied access to health care, culturally competent representation, and care provision (Lassiter, 2017). For the purposes of this paper, I choose to isolate the social problem of LGBTQAI+ health access disparities to the intersection of gender and sexual minority status, which is simultaneously broad enough to produce illuminative disparities in the way marginalized communities gain access to health care, yet discrete enough to provide specific examples of how care is out of reach for the most vulnerable in ways that transcend racial and ethnic identity.

STRUCTURAL ISSUES FOR SEXUAL MINORITY WOMEN

LGBTQAI+ individuals who are female-identified (sexual minority women, SMW) experience higher barriers to health care and poorer long-term health outcomes than their heterosexual or male counterparts across race, ethnicity, and ability (Lunn et al., 2017). SMW experience poorer long-term health outcomes and higher barriers to health care than male-identified members of the LGBTQAI+ community or cisgender heterosexual women (Eckstrand et al., 2017; Lunn et al., 2017). SMW are less likely than gay or bisexual men to have a primary care provider and health insurance (Lunn et al., 2017). SMW are more likely to have chronic health conditions, such as obesity or substance use disorder (Lunn et al., 2017). Additionally, SMW are less likely to enroll in traditional

business services. Despite great strides for sexual and gender minority inclusivity under the Obama administration, homophobia and transphobia may be on the rise under this administration. For the purposes of this paper, I will operate under the assumption that society has made and is making great strides towards equity, which cannot be undone in a few, inelegant legal maneuvers.

employment, requiring them to secure insurance outside of the workplace (Lunn et al., 2017; Eckstrand et al., 2017). Consequently, the population as a whole is not likely to be engaged in workplace diversity initiatives and wellness programs, which help moderate risk behaviors (Eckstrand et al., 2017). SMW are also less likely to enroll in spousal health care due to lower rates of marriage among the population (Blosnich, 2017).

Even when SMW enroll in healthcare, they are less likely to experience quality of care and culturally-competent service provision (Blosnich, 2017). On the whole, SMW report lower satisfaction rates with primary care provision than their heterosexual or sexual minority male counterparts (Baldwin, Dodge, Schick, Sanders & Fortenberry, 2017). Lower satisfaction rates and lack of culturally competent service provision lead to difficulties in securing a continuum of care, which addresses chronic health issues and provides preventative care (Baldwin et al., 2017). Most indicative of structural inequity, the needs of SMW are not adequately reported or measured by researchers (Patterson et al., 2017).

People with means have access to quality health care (Marmot, 2005). In the United States, economic inequity rests at the heart of health care disparities (Fiscella & Williams, 2004). Women are economically disadvantaged as compared to men, after lower entry-level salaries and gross income disparities (Hegewisch & Williams-Baron, 2018; National Women's Law Center, 2017; Kirkpatrick, 2018). And—even after *Obergefell v. Hodges*—sexual minorities are less likely to enjoy the stabilizing economic benefits of marriage, such as dual-income households, spousal health insurance, domestic workload sharing, or provision in the event of illness (Eckstrand et al., 2017). Despite reports suggesting that SMW receive an earnings premium compared to heterosexual women, SMW make less than men, so SMW couples experience a compounding of the gender wage gap (Alexander & Ravani, 2016; National Women's Law Center, 2017). The earnings premium is marginal at best and does not undo the exorbitant gender wage gap. Indeed, poverty rates among female-identified same-sex couples are approximately eight percent, which is higher than poverty rates among heterosexual couples (S.K., 2016). Lastly, workplace discrimination destabilizes job security and then disrupts health insurance and continuation of care (Badgett et al., 2007). Consequently, health insurance mandates such as those advocated by the Affordable Care Act represent the single greatest barrier removal to health access (Housel & Harvey, 2017). Though the health insurance mandate is a promising start, the disproportionately low rate of health access for this population necessitates additional protections across all practice areas, such as provider training for culturally competent care, the expansion of anti-discrimination provisions, government collection of demographic data to track and assess population health outcomes, and youth education curricula.

INTERVENTIONS IN ADVOCACY AND TRAINING

LGBTQAI+ affirmative laws improve health outcomes because they legitimize individuals, improve societal attitudes, and—most importantly—lessen minority stress (Buffie, 2011). Because the community has only recently been legitimized through legal avenues—and thus has only recently been identified as a valuable data point to track in health care—there is a dearth of relevant research for interventions and health outcomes (Patterson et al., 2017).

Policy interventions exist at various system intersections. Continued legal legitimacy is a necessity. In 2017, sexual orientation and gender identity are still not protected classes (Foti, 2017).[5] Providing government oversight of discriminatory practices and establishing a department or team to oversee these rules of law would improve equity (Mule et al., 2009). Mandating sexual orientation and gender identity inclusion in research collection would generate the data necessary to provide adequate health care to these populations by observing trends and practice solutions (Patterson et al., 2017). Provider education including training providers on asking the right questions appropriately, and encouraging more LGBTQAI+ individuals to enter care services would ensure that practice is inclusive, accessible, sensitive, and equitable (Lassiter, 2017; Mule et al., 2009). In addition, creating programming that builds self-esteem, body autonomy, and self-advocacy skills—such as those taught in many youth programs and Gender and Sexualities Alliance groups—may improve health outcomes through the creation of self-advocates and conscious consumers of medical care (Poteat et al., 2013).

ANTI-DISCRIMINATION
PROTECTIONS AND DATA COLLECTION

Though the LGBTQAI+ community has still not achieved protected class status and there is much room for improvement, health policy has evolved to be more inclusive and sensitive to the specialized needs of the population. As funders and governments continue to promote evidence-based practice (Durso, 2017), social workers must push for sound evaluative processes and data collection to provide visibility to the population and create policies that reflect the true landscape of the LGBTQAI+ client experience.

We must continue to work towards macro-level policy changes at all levels of government, protecting the community from discrimination and wage disparity, and providing avenues for compliance and enforcement.

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[5] The Equal Employment Opportunity Commission (n.d.) released an anti-discrimination doctrine for sexual orientation and gender identity, which provides supportive policy to stabilize the workforce for this population, and thus economic security and access to health care.

To date, 47% of the LGBT population live in states that protect them from gender or sexual orientation discrimination in the workplace or in public accommodations (Movement Advancement Project, 2018). The establishment of localized LGBT government agencies—such as those developed in Philadelphia, D.C., and San Francisco—promotes civil rights policy, coordinates services across cities, develops infrastructure for culturally competent training, collects outcome data, and enforces high standards of service delivery (City of Philadelphia, 2018; DC Mayor's Office, 2018; San Francisco Human Rights Commission, 2018).

Similarly, the creation of an LGBTQAI+ serving bureau at the Department of Human Health Services (HSS) would serve as the appropriate tool for collecting data, enforcing policy, and making recommendations for future protections. In 2010, HSS recommended the collection of LGBT data collection through the Healthy People 2020 initiative (HSS, 2018). While doing so is an adequate step, mandating data collection in medical, U.S. Census, and American Community Survey records would further legitimize the population and ensure that pertinent data points are studied and reviewed—a critical step because much of the current reporting on LGBTQAI+ health comes from provider conversations and anecdotal evidence (Durso, 2017). We cannot know the true disparity without concrete quantitative data to support qualitative research.

PROVIDING TRAINER PROGRAMS

LGBTQAI+ visibility in health care settings requires disclosure (Rondahl, Innala & Carlsson, 2006). SMW "look like everyone else...act like anyone else, and possess no identifiable or unique characteristic" (Willes & Allen, 2014). Disclosure of sexual identity or sexual practice is the gateway to informed care and selection of services (Smith & Turell, 2017). Sexual and romantic practice intertwine so closely with our physical and mental health that refusal to acknowledge them in health care is detrimental to the whole person approach to service delivery (Willes & Allen, 2014).

And yet, the burden for quality care currently rests on the client's self-disclosure, self-advocacy, and protection of one's own health information (Smith & Turell, 2017). Many providers do not ask their clients' sexual orientation because they assume heterosexuality, feel uncomfortable including sexual orientation in the psychosocial model of care, or do not consider it necessary due to their heterosexist lens and a misunderstanding of their clients' experiences (Rondahl et al., 2006; Talan et al., 2017; Spiekermeier, 2017). Worse yet, many SMW feel misunderstood or aggressed upon by their providers, or else forcibly outed, so much so that they do not want to engage in services again (Martos et al., 2017). This failure to deliver culturally competent, or even culturally aware, care by requiring clients to carry the burden of disclosure creates a fissure between the client and their care team, further exacerbating health disparities.

Enacting direct service policies that standardize best practice would help interrupt health care disparities from the ground up (Spiekermeier, 2017). As with all high-needs populations, a solution can revolve around investment in standardization of services, creation of treatment plans for specific needs, and empathic communication of care (Mehta, 2017; Spiekermeier, 2017; Eckstrand et al., 2017). Training providers on best practice, continuing professional education, and implementing standardized protocols would serve as a mezzo-level intervention for the protection of the community in direct practice (Spiekermeier, 2017). Service models that privilege flat affect, open-ended questions, non-judgmental questioning, and requesting permission in the delivery of care may yield the best results (Eckstrand et al., 2017; Mehta, 2017).

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YOUTH HEALTH EDUCATION CURRICULA

Lastly, in micro practice, social workers can promote early intervention by engaging youth in appropriate health education (Poteat et al., 2013). Young people who are more informed about their bodies and health outcomes tend to adopt healthier lifestyles (Da Silva Vilelas Janeiro et al., 2013). Affirmative health curricula teaching bodily autonomy build self-esteem and respect for persons, and prime participants to be conscious consumers of medical care (Keuroghlian et al., 2017). For children, this type of intervention can result in self-sufficiency and self-determination, and act as a protective factor over the lifespan.

Family is the first point of contact for youth in providing vocabulary and understanding body function and expression. Additionally, family members may act as gatekeepers to health services for youth. This dynamic may present a barrier for LGBTQAI+ identified youth who need to rely on their families for determination and care, which may be at odds with the youth's identity, expression, or behavior. Consequently, youth health education incorporating gender and sexual orientation may further legitimize identity and promote clarity for youth (Keuroghlian et al., 2017).

CONCLUSION

Equity rests at the heart of social work practice (National Association of Social Workers, 2017). Equity requires the fair distribution of services and resources, especially in a health setting (Omrani-Khoo et al., 2013). Although the concept of fairness is subjective, the modern understanding

of equity means that we push services and resources towards those who need it most to maintain average—if not basic—access to social and economic survival. When working with people and communities that have been greatly disenfranchised, social workers are required by the Code of Ethics to consider the intersectional identities and experiences that restrict access to resources (National Association of Social Workers, 2017). Though the LGBTQAI+

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community has been greatly disenfranchised, and is only just receiving the legal protection it deserves, cis and trans women in the community experience enormous inequity in the provision and distribution of social services, health care, and employment. We must consistently provide interventions at the macro, mezzo, and micro levels to promote economic and health parity for female-identified members of the LGBTQAI+ community.

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JENNIFER HAND, located in San Francisco, is a Masters of Science in Social Work candidate in the Social Enterprise Administration program at Columbia University's School of Social Work. The SEA program provides training across all three levels of social work practice, with emphasis on management and policy. Her Field of Practice is health, mental health, and disability. For her second-year placement, Jennifer works at the Mayor's Office of Economic and Workforce Development where she researches and assesses programs to promote equity and improve data collection. Additionally, Jennifer works as a gender and sexuality health educator and chairs the LGBTQ Community Services and Education Committee at the San Francisco Planning Department. Prior to attending Columbia University, she worked in the legal industry, small business management, and created a workforce navigator model for professionals managing severe mental illness. She attended Stony Brook University in New York for her B.A. in English and Education.