



Gay and Lesbian Health Disparities: Evidence and Recommendations for Elimination

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Abstract

Research suggests that significant health disparities exist among the gay and lesbian population in the United States. These disparities impact both the short- and long-term health outcomes of this population. This study first provides a current literature review of available research on gay and lesbian health disparities and organizes these findings according to health topic. The paper then investigates recommendations for the elimination of racial and ethnic health disparities and examines their applicability in eliminating sexual minority disparities. While many recommendations are valid, this paper analyzes the six thought to have the greatest potential in eliminating gay and lesbian health disparities. These recommendations are then prioritized using three criteria. Ultimately, this study examines the factors that contribute to this issue, and discusses how researchers, organizations, and policy-makers must work together to eliminate these health disparities.

Key Words: Gay and Lesbian, Health Disparities, Policy Recommendations

Introduction

The federal Department of Health and Human Services (DHHS), in its Healthy People 2010 report, defines health disparities as the “unequal burden in disease morbidity and mortality rates experienced by [minority] groups as compared to the dominant group” (US Department of Health and Human Services [DHHS], 2000). In other words, a health disparity exists between two groups when one group has a higher incidence or prevalence of disease or experiences a higher rate of death because of a health condition. The Health Resources and Services Administration (HRSA), which focuses its efforts on eliminating health disparities, defines the term as “population-specific differences in the presence of disease, health outcomes, or access to health care” (US DHHS HRSA). Research indicates that health disparities

in the United States are often associated with an individual's race and ethnicity, gender, income level, sexual orientation, or geographic location. Most health disparities are not rooted in physiological differences between population groups, but in social, economic, and cultural differences that exist within society. Forms of oppression such as classism, sexism, racism, and heterosexism play a much deeper role in the existence of health disparities than do biological differences between population groups.

This paper focuses on health disparities based on sexual orientation and the role of heterosexism in these disparities. Heterosexism "refers to characteristics of an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community" (Dean, et al., 2000, p. 102). Heterosexism and homophobia contribute to gay and lesbian health disparities because of their role in the inadequate prevention, diagnosis, and treatment of health problems. Although this study focuses on heterosexism's role in health disparities, many lesbian and gay individuals encounter other forms of oppression that increase the negative impact on their health status. For example, an African-American gay man would experience the effects of both racism and heterosexism. This is often termed double jeopardy. If a person is additionally impacted by sexism or classism they may experience triple or even quadruple jeopardy (National Coalition for LGBT Health, 2002, p. 2).

Of the diverse minority populations impacted by health disparities, the literature primarily focuses on racial and ethnic differences. Health data clearly show that racial and ethnic minority groups in the United States (e.g. African Americans) have higher rates of chronic diseases, higher mortality rates, and poorer health outcomes than individuals classified as white (Committee on the Review and Assessment of NIH's Strategic Research Plan, 2006). For example, racial minorities in the United States have higher rates of cancer, cardiovascular disease, diabetes/kidney disease, HIV/AIDS, and infant mortality compared to their white counterparts.

While race-based health disparities have been well documented and efforts have been initiated among numerous health-related organizations to eliminate these differences, the research and evaluation of health disparities based on sexual orientation remains limited in depth and scope. Population-level health data for gays and lesbians are not available because national health surveys virtually never include questions that assess sexual orientation (Gay and Lesbian Medical Association [GLMA], 2001, p. 1). Stigmatization, political obstacles, prejudice, and methodological challenges (e.g. recruitment of subjects and definitions of homosexuality) combine to limit the available research on gay and lesbian health issues. Much of the available data come from small studies that often use convenience samples and are therefore not

always reliable. Only recently has research on this topic become more reliable as studies have strengthened their methodology, making the results more likely to be generalizable to the larger gay and lesbian population.

The first portion of this paper surveys the available data on health conditions for which disparities exist based on sexual orientation. Some of these health disparities are applicable only to gay men or lesbians but not to both; however, most of the topics discussed are applicable to both populations. Next, this study examines recommendations that have been made for the elimination of racial health disparities and considers their applicability for eliminating health disparities based on sexual orientation. Finally, the paper concludes with recommendations for how health researchers and practitioners can move forward in addressing gay and lesbian health disparities in the United States.

Lesbian and Gay Health Disparities

Access to Health Services

In order to effectively prevent or treat the health concerns of lesbians and gays, these individuals and their families must have access to appropriate and quality health care services. A major barrier to accessing health services is a lack of health insurance. Research indicates that gays and lesbians may have a higher rate of uninsurance than the general population (Badgett, 1998). The research in this area is better documented for lesbians than for gay men (National Women's Law Center, 2004, p. 208; US DHHS Office of Women's Health, 2000, p. 3-4; Drabble, 2000, p. 9). Many gay men and lesbians are self-employed or work part-time and therefore have few or no health insurance benefits. Additionally, although more companies are beginning to offer domestic partner benefits to their employees, the overall percentage remains very small. Lesbians and gay men cannot obtain health insurance for their partner through an employer like a heterosexual married couple because they are denied access to marriage or civil-unions in the vast majority of states. Furthermore, even if an employer offers domestic partner benefits that include health insurance, these benefits are taxed as income, unlike health benefits for married heterosexual couples (Bennett & Gates, 2004, p. 9-10). Therefore, this leaves gays and lesbians at a distinct disadvantage in obtaining health insurance benefits for either their partner or children. For these reasons, a disparity exists between gay and lesbian individuals and their heterosexual peers in regard to the rate of uninsurance. Being uninsured decreases an individual's access to health care services and ultimately results in worse health outcomes (see Exhibit 1).

Exhibit 1. Consequences of Uninsurance

In the United States the uninsured:

- have worse health outcomes,
- enter the health care system in poorer health,
- lack needed medical care,
- receive less screening and preventive care, and
- receive less care for serious illnesses and chronic conditions.

Source: Hadley, Jack, "Cover Missouri Project: Report 1: Consequences of the Lack of Health Insurance on Health and Earnings," Missouri Foundation for Health, 2006

Another issue in accessing appropriate health services involves gays and lesbians feeling comfortable enough with their health care providers to reveal their sexual orientation. Providers can not be attentive to the health needs of their gay and lesbian patients if the patients do not feel safe enough to reveal or discuss their sexuality. In a 2000 Kaiser Family Foundation (KFF) survey, 64 percent of gay and lesbian respondents had voluntarily told their doctors about their sexual orientation (KFF, 2001). However, this leaves 36 percent who are not informing their health care providers about a salient fact in receiving appropriate services. Another survey found that 60 percent of young gay and lesbian adults do not reveal their sexual orientation to their doctor (The Medical Foundation, 1997, p. 3). "This lack of disclosure can have detrimental effects, not only in specific areas such as the treatment of STDs but, more broadly, in limiting the practitioner's ability to understand the factors affecting the patient's health and to treat the whole person" (The Medical Foundation, 1997, p. 3).

This reluctance to fully inform health care providers stems from provider bias relating to the lesbian and gay population, which has been documented in several studies (GLMA, 2001, p. 49). At best, many health care providers may be uncomfortable, reluctant, or under-trained in their competency to work with this population (Weinick, Zuvekas, & Drilea, 1997). At worst, providers may be hostile to gays and lesbians and view homosexuality as a "sickness." Some health care providers have described this population as "deserving of illness" or "unworthy of treatment" (Schatz & O'Hanalan, 1994). It is therefore not surprising that many gay and lesbian patients are reluctant

to inform their doctors of their orientation. Unfortunately, this bias leads to gays and lesbians not seeking appropriate preventive screenings, delaying treatment for health conditions, and not receiving maintenance services for chronic conditions.

A final disparity that exists in relation to gays and lesbians accessing quality health services involves legal issues that are pertinent to this population. Currently in the United States, gays and lesbians and their partners lack the legal rights of hospital visitation, access to health information, participation in treatment decisions, and health care proxy appointments (US DHHS Office of Women's Health, 2000, p. 4). Lesbian and gay couples must obtain legal documents (e.g. durable power of attorney, health proxy, etc.) that authorize mutual medical decision making; something that married heterosexuals take for granted. Without these legal documents, the partner of a gay or lesbian may be overridden by blood relatives that know less about the patient's ethical, medical, or religious preferences (O'Hanalan, Cabaj, Schatz, Lock, & Newrow, 1997). These legal issues may cause stress and anxiety for gays and lesbians entering into the health care system in the United States and is an access issue that most heterosexuals do not face.

Mental Health

Another health issue where significant disparities exist for the gay and lesbian population is in the arena of mental health. Mental health is a state of being where individuals can successfully perform mental functions in order to engage in productive activities, meaningful relationships, deal with change, and handle adversity. Mental disorders are health concerns that are distinguished by changes in thinking, disposition, behavior, or a combination of the preceding. In the United States, gays and lesbians have higher rates of mental disorders such as depression, anxiety, and suicide compared to the general population (Bradford, Caitlin, & Rothblum, 1994; Justice Research Institute, 1995). A recent population-based study in the *American Journal of Public Health* reported that the social stigma of homosexuality and discrimination have a negative affect on the mental health of gays and lesbians and puts them at a higher risk of psychiatric morbidity (Mays & Cochran, 2001). A 2004 household-based probability study focused on gay men found the prevalence of depression in gay men to be 4.5 to 7.6 times higher than their heterosexual peers (Mills, et al., 2004).

In examining mental health issues such as depression, anxiety, and stress it is important to understand the root causes of the disparities that exist for this population. A 2001 study that used both univariate and multivariate analyses found that mental health difficulties among sexual minorities are

directly related to the social context of heterosexism as a form of oppression (Diaz, Ayala, Bein, Henne, & Marin, 2001). This oppression leads to social alienation, low self-esteem, and psychological distress. Research has associated these mental health concerns with lacking a partner, episodes of antigay violence, identity crises, "coming-out" issues, and community and family isolation (Mills, et al., 2004). Social stigma and homophobia have a definite and negative impact on the mental health of gay and lesbian persons.

As mentioned in the introduction, discrimination and oppression permeate all sectors of society and institutions. Unfortunately, when gays and lesbians seek treatment for mental health issues they may experience the same social discrimination that contributed to their mental health issues. Until 1973 homosexuality was classified as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders used by mental health professionals. Although the American Psychiatric Association (APA) has issued a position statement that affirms gays and lesbians and recognizes the social stressors that are correlated with mental health issues, many mental health professionals remain untrained, insensitive, or unwilling to work with gay and lesbian clients. Furthermore, some mental health professionals still attempt "reparative" or conversion therapy to "cure" or change a person's sexual orientation. Although there is no scientific evidence supporting the efficacy of this treatment, one study found that almost 10 percent of respondents stated that their psychotherapist recommended or attempted the alteration of their sexual orientation from homosexual to heterosexual, although none of the clients had expressed this desire (Nystrom, 1997).

A final area of concern relating to mental health issues in the gay and lesbian population is the high rates of suicide ideation and attempts among this population. A 2002 study of gay men found a link between societal stressors, emotional distress, and suicide. The study found that 21 percent of gay men had made a suicide plan and 12 percent had attempted suicide (Paul, et al., 2002). These rates are elevated compared to heterosexual men where only 3.6 percent have attempted suicide. Another study found that the risk of suicide was greatest at the developmental point when youths come to identify as gay, lesbian, or bisexual, but have not disclosed this to family or friends (D'Augelli, Hershberger, & Pilkington, 2001). Studies directed at youth have found suicide ideation and attempts among gay and lesbian youth to be three to seven times higher compared to their heterosexual peers (Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautrais, 1999; Remafedi, French, Story, Resnick, & Blum, 1998). Suicidal ideation, especially among young gay and lesbian youth just coming to terms with their sexual orientation, is an area of major concern because of the high rate of mortality associated with this issue (see Exhibit 2).

Exhibit 2. Sexual Minority Youth and Suicide

“The increased suicidal risk in this age range appears to be not simply a mental health concern but rather a broader issue of the effect of societal discrimination and harassment. If we cannot change some of the environment in which lesbian, gay, and bisexual youths come to maturity, the alienation, isolation, and victimization they frequently encounter will continue to take their toll.”

Source: Paul, et al., “Suicide Attempts Among Gay and Bisexual Men: Lifetime Prevalence and Antecedents,” *American Journal of Public Health*, 2002, 92.8, 1343.

Substance Use/Abuse

Substance use and abuse is a health concern that affects all populations in the United States; however, rates of alcohol, drug, and tobacco use may be significantly higher among gays and lesbians. Much of the data available regarding this topic come from studies that use convenience samples and are therefore not as reliable as random sampling. While it seems alcohol use among the gay and lesbian community has been declining, there is some indication that rates of alcohol use are still higher than in the general population. Studies suggest that lesbians are more likely to drink and more likely to experience alcohol-related problems than their heterosexual counterparts (Bradford & Ryan, 1987; McKirnan & Peterson, 1989; Skinner, 1994). For gay men, a 2001 probability telephone sample found high rates of both recreational drug use (52%) and alcohol use (85%). Additionally the study found rates of multiple drug use (18%), three or more alcohol-related problems (12%), frequent drug use (19%), and heavy-frequent alcohol use (8%) that were significantly higher than the general adult population (Stall, et al., 2001). Unlike their heterosexual peers, research indicates that the alcohol consumption rate for gays and lesbians does not decrease as dramatically with age (Skinner, 1994; Bradford, et al., 1994).

Drug use among the lesbian and gay community may also be a health issue of concern, especially among young members of this community. One study of gay men and lesbians found lesbians in some age groups to have higher rates of marijuana and cocaine use compared to the general population. In the same study, gay men indicated higher overall use rates of

inhalants, hallucinogens, and illicit drugs (Skinner & Otis, 1996). Drug use may be an even greater health concern for younger gays and lesbians. One study reported an overall rate of 87.1 percent for young gay men for use of any illicit drug, and an overall rate in excess of 80 percent for young lesbians (Skinner & Otis, 1996). A youth behavior surveillance survey found that gays and lesbians had an increased lifetime incidence of use of cocaine, crack, anabolic steroids, inhalants, "illegal," and injectable drugs. Additionally, sexual minority youth are more likely to report tobacco, marijuana, and cocaine use before age 13 compared to their heterosexual peers (Garofalo, Cameron Wolf, Kessel, Palfrey, & DuRant, 1998).

Under the topic of substance use, high rates of tobacco use in the gay and lesbian community are a well-documented health disparity. Research indicates that tobacco use among sexual minority men and women is strikingly higher than the general population. In fact, gays and lesbians are 40 to 70 percent more likely to smoke than the heterosexual population (Ryan, Wortley, Easton, Pederson, & Greenwood, 2001). Gay and lesbian adolescents once again exhibit large disparities compared to their straight peers in that 45 percent of lesbian youth and 35 percent of gay male youth reported tobacco use compared to 29 percent of the non-gay youth (Petrov, [n.d.]).

Interestingly, higher levels of substance use in all categories may be partially tied to social stressors and stigmatization of the gay and lesbian community. Alcohol and drug use, as well as smoking, are linked to mental health concerns in that these substances may work as coping mechanisms for social stressors and depression. Additionally, high substance use may also stem from the large presence of the bar and club scene in the gay community, as well as targeted campaigns by the alcohol and tobacco industry (Coalition of Lavender-Americans on Smoking, 1994). For whatever reason these disparities exist, substance abuse is a concern among the gay and lesbian population because it can lead to impaired judgment and has a direct tie to some of the sexual health concerns that will be discussed in the following section.

Sexual Health

Sexual health disparities for gay men and lesbians differ greatly. While gay men show higher rates of sexually transmitted diseases (STDs) than straight men, lesbians may have similar or even lower STD rates than their heterosexual peers. However, disparities do exist for lesbians regarding preventive services and screenings related to their sexual health. Additionally, myths have developed that lesbians have little to no risk of STD infection when in fact sexual activity between women can still transmit many different kinds of STDs including Human Papillomavirus (HPV) and trichomonas (Carroll, Goldstein, Lo, & Mayer, 1997).

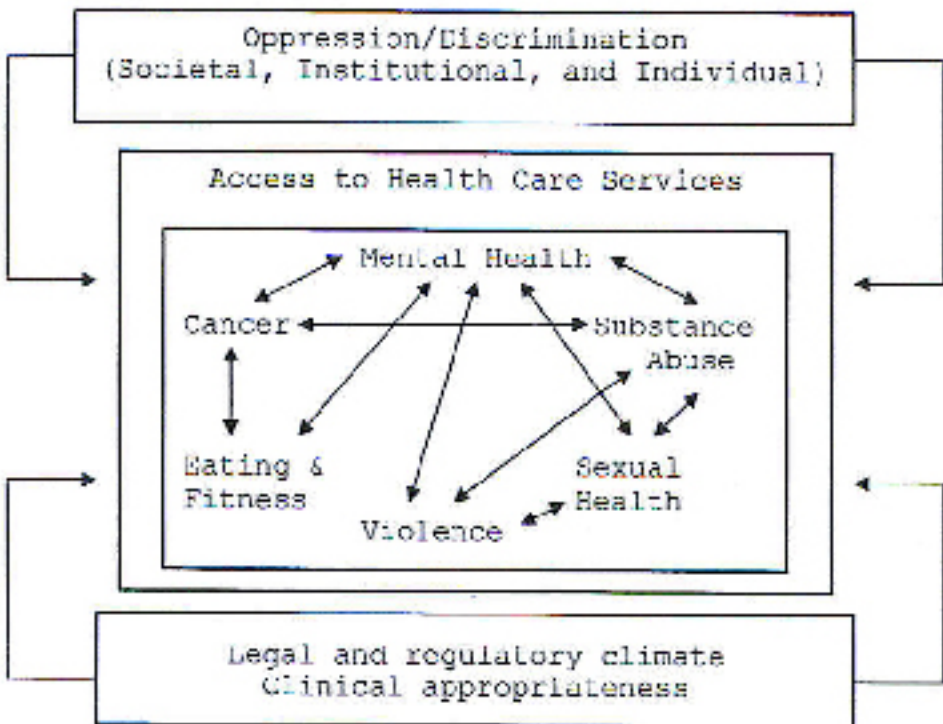
Gay men are at an increased risk for contracting STDs, including Human Immunodeficiency Virus (HIV), compared to their heterosexual counterparts. From 2001 to 2003, nearly 71 percent of those diagnosed with HIV or Acquired Immune Deficiency Syndrome (AIDS) were men, and in 61 percent of these men the principal method of infection was male-to-male sexual contact (US DHHS Centers for Disease Control and Prevention [CDC], 2005). Additionally, the prevalence of HIV is growing among the young gay male population. A recent study showed that 7 percent of gay men 18-24 years of age in seven urban areas were HIV-positive, a rate significantly higher than in the general male population (Valleroy, et al., 2000). While research does not indicate that gay men are biologically more susceptible to HIV infection, there are biological factors associated with male-to-male sexual activity (i.e. anal intercourse) that increases the risk of acquiring HIV.

Gay men are also at an increased risk for STDs other than HIV, including urethritis, prostatitis, hepatitis A and B, syphilis, gonorrhea, chlamydia, herpes, and genital warts/HPV (GLMA, 2001, p. 307). Immunizations exist for hepatitis A and B and health practitioners are urged to encourage their gay male patients to receive these vaccines. While the prevalence rate of these immunizations is mostly unknown, one study sample of young gay men found that only 3 percent were vaccinated for hepatitis B (Dean, et al., 2000). Many of the other STDs could be prevented through safer sex measures; however, research shows an increase in the proportion of gay men who report having unprotected anal sex (Meyer & Dean, 1995). Unfortunately health care providers are not educated or culturally aware enough to know to screen for STDs that may present rectally. Therefore these infections often go undiagnosed and untreated, and can contribute to an increased risk of HIV infection (Wasserheit, 1992).

In comparison to gay men, lesbians may in fact have a lower prevalence of STDs; however, research in this area remains incredibly scarce and more information is needed. Lower infection rates may exist for lesbians for some STDs such as gonorrhea and syphilis; however, similar rates as seen in heterosexual women may be present for other types of STDs such as HPV, genital herpes, and HIV (Dean, et al., 2000). An important note is that studies show that many women that have sex with women have had past sexual relations with men (53%-99%) and some (21%-30%) continue to have sex with men (Diamant, Schuster, McGuigan, & Lever, 1999). Having sexual contact with men, or having sexual contact with a woman who has been with a man, puts lesbians at risk of contracting virus based STDs. Additionally, because lesbians are less likely to have Pap test screenings, they may have undetected STDs, especially HPV, that go untreated and can lead to complications in the future (Marrazzo, Koutsky, Kiviat, Kuypers, & Stine, 2001).

Studies have documented the link between alcohol and drug use and STDs (Beltrami, et al., 1997). Both legal and illegal substances can affect an individual’s cognitive and negotiating abilities before and during sex. This lowers the probability of condom use and increases the likelihood of multiple sexual partners (US DHHS CDC, 2004). Additional studies have also linked depression in gay men directly with increased risky sexual behaviors (Perdue, Hagan, Thiede, & Valleroy, 2005). Increasingly health professionals and researchers have made this type of connection between different health concerns (e.g. the impact of mental health issues on an individual’s sexual health). Not only do these health concerns interrelate amongst each other, but they are also connected through different forms of oppression (i.e. health disparities affecting minority populations). Exhibit 3 shows the interrelation between these health concerns, as well as how access to health care, oppression, legal factors, and the clinical appropriateness of provider care play a role in the existence of health disparities.

Exhibit 3. The Interrelation of Factors Contributing to Health Disparities



Cancer

Although additional research is needed due to sexual orientation questions not being included in national cancer surveys and registries, there is some indication that gays and lesbians may be at a higher risk for developing certain forms of cancer. Lesbians may be at higher risk for breast cancer and gynecological cancers such as ovarian cancer. Gay men have an increased risk of Kaposi's sarcoma (KS), non-Hodgkin's lymphoma, and anal cancer. Additionally, research is needed to understand not only the natural history of these cancers in lesbians and gays, but also the link between mental health issues such as stress and depression and the suppression of the immune system, which may increase cancer risk (Cole, Kemeny, Taylor, & Visscher, 1996).

Breast cancer is one of the most studied of the health concerns for lesbians. Lesbians may be at a higher risk for breast cancer compared to heterosexual women because of risk factors such as high smoking rates, greater obesity rates, increased alcohol consumption, never being pregnant (i.e. nulliparity), and lower rates of breast cancer screening (Denenberg, 1995; Haynes, 1995). Many women access health screenings and preventive services through the use of family planning programs. However, since many lesbians do not utilize birth control pills or other contraceptives, they are less likely to receive routine breast cancer screenings and gynecological exams (Robertson & Schacter, 1981). This lack of gynecological care might cause higher morbidity and mortality rates for lesbians from undiagnosed and untreated gynecological cancers, especially ovarian cancer. Discrimination or heterosexist behaviors by health care providers, whether purposeful or subconscious, may disincline lesbian patients from receiving proper health screenings that offer early detection and treatment of cancers.

At the beginning of the AIDS epidemic, before the advent of advanced antiretroviral therapies, gay men had rates of KS that were thousands of times greater than the general population (Koblin, et al., 1996). Because HIV weakens the immune system, KS was seen in the majority of patients with AIDS. Additionally, this cancer has been linked to the presence of the herpes virus, which has a higher prevalence among the gay male population (Martin, et al., 1998). Fortunately, new HIV therapies have reduced the incidence of KS by preventing HIV from replicating in the body and therefore destroying the person's immune system. The incidence of AIDS-related non-Hodgkin's lymphoma is also higher in the gay male population (Koblin, et al., 1996), although never to the extreme seen with KS. Unfortunately, while HIV drugs have reduced the incidence of KS, they have not had as great an effect on the rate of non-Hodgkin's lymphoma among HIV-positive individuals (Dean, et al., 2000). Because gay men still comprise a greater percentage of HIV-positive

individuals, their rates of KS and non-Hodgkin's lymphoma are elevated compared to the general population.

Finally, gay men are at an increased risk of anal cancer which has been linked to both HPV and anal squamous intraepithelial lesions (Breese, Judson, Penley, & Douglas, 1995). One study found the prevalence of HPV to be at 93 percent for HIV-positive gay men and 61 percent for HIV-negative gay men (Palefsky, Holly, Ralston, & Jay, 1998). HPV risk has been associated with receptive anal intercourse, multiple sex partners, and rectal administration of recreational drugs (Palefsky, et al., 1998; Breese, et al., 1995). Furthermore, higher smoking rates among gay men may increase their risk of anal cancer (Daling, et al., 1987). Overall survival rates for gay men with cancer may be lower than the general population because of decreased access to screening and preventive measures, as well as late diagnosis and treatment of these cancers (Koblin, et al., 1996). For both gay men and lesbians cancer mortality rates may be higher than the heterosexual population because of the many access issues discussed earlier (e.g., higher uninsured rates, legal issues, and health care provider issues).

Eating and Fitness

As with many of the previously discussed health topics, the data and research to date on health disparities involving the fitness and eating habits of lesbian and gay men is mostly non-randomized sampling. Once again this is due to the lack of inclusion of questions on national surveys and health records regarding sexual orientation. However, initial studies indicate that gay men and lesbians may have higher incidence of certain conditions that relate to eating and fitness concerns.

Obesity and being overweight is a national epidemic in the United States. Using the Body Mass Index (BMI) scale as an indicator shows that more than 65 percent of the nation is now considered overweight or obese (US DHHS CDC, 2006). Some studies show that lesbians are more likely to be overweight or obese compared to heterosexual women (Siever, 1994). Higher BMI is associated not only with genetic factors, but also with poor nutrition (GLMA, 2001, p. 244). One study found that lesbians are less likely to consume fruits and vegetables compared to their heterosexual peers (Valanis, et al., 2000). On the other hand, studies have also showed that lesbians may be less preoccupied with body image and weight compared to straight women (Siever, 1994). This may indicate that lesbians may have an equal or lower rate of eating disorders such as bulimia and anorexia compared to their heterosexual peers.

Conversely, some studies show that gay men may have higher rates of eating disorders compared to straight men (Herzog, Norman, Gordon, & PePOSE, 1984; Beren, Hayden, Wilfley, & Grilo, 1996). Today's gay male culture seems to have a narrow norm for gay male attractiveness that men in this community try to conform to. This need to conform may lead to higher rates of body dissatisfaction, as well as an increased incidence of anorexia and bulimia compared to their straight male peers (Carlat, Camargo, & Herzog, 1997).

Eating and fitness related health disparities may be more pronounced among young gay and lesbian persons. In fact, in a state level survey of adolescents, homosexual boys were more likely than heterosexual boys to report poor body image (28% vs. 12%), frequent dieting (9% vs. 6%), binge eating (25% vs. 11%), and purging behaviors (12% vs. 4%) (Neumark-Sztainer, Story, Resnick, & Blum, 1998). Conversely, lesbian adolescents were more likely than their heterosexual peers to report a positive body image (42% vs. 21%), but were no less likely to report negative eating behaviors (Rogers, Resnick, Mitchell, & Blum, 1997). Overall, despite an elevated frequency of body dissatisfaction and eating disorders among homosexual men compared to heterosexual men, women (either lesbian or straight) still have a greater incidence of these health conditions compared to men (Dean, et al., 2000).

Finally, there is a subset of the gay male population, called "bears," that may be at higher risk for poor health outcomes that correspond with poor nutrition and being overweight. These men characteristically celebrate large bodies as more masculine and usually identify a sexual attraction to other large men. One non-random sample study conducted in New York City found that "bears" self-identified "compulsive overeating" as their top health concern (GLMA, 2001, p. 245). More research needs to be conducted to determine the extent of this problem and the health risks for this population.

Violence

Violence is a health issue that affects the gay and lesbian community both from external sources (e.g. hate crimes) and from within their own community (e.g. domestic violence). Acts of hostility, defamation, and violence against gays and lesbians have been known to occur in many different locations, such as schools and colleges, the armed services, jails and prisons, in their homes, workplaces, and in public places (Dean, et al., 2000). Adult gay and lesbian individuals report high incidences of verbal abuse and physical violence because of their sexual orientation. One survey reported that:

- 74 percent of gays and lesbians report having been the target of verbal abuse (e.g., slurs and name-calling),
- 32 percent say they have been the target of physical violence, against either their person or property, because of their sexual orientation,
- 41 percent of lesbians and gay men believe that there is more violence directed at them today in this country compared to a few years ago, and
- 39 percent report to being “very” or “somewhat” worried that they may be physically assaulted or beaten by someone who does not like gay people (KFF, 2001, p. 2-3).

A Department of Justice report found that gays and lesbians are among the most frequent victims of hate crimes in the United States and that as a group they “are probably the most frequent victims” (Finn & McNeil, 1987). Hate crimes targeted at this population include verbal harassment, threats of violence, vandalism, arson, bomb threats, physical assault, sexual assault, and homicide. Furthermore, when hate crimes targeted at gays and lesbians escalate to the point of homicide they are frequently more violent than in the general population (Comstock, 1991).

It has also been found that violence towards sexual minorities has a very early onset and strongly impacts gay and lesbian youth. The 2003 National School Climate Survey found that:

- 84 percent of lesbian and gay students report being verbally harassed,
- 91.5 percent of gay and lesbian students report hearing homophobic remarks, such as “faggot,” “dyke,” or the expression “that’s so gay” frequently or often,
- 82.9 percent of sexual minority youth report that faculty or staff never intervened or intervened only some of the time when present and homophobic remarks were made,
- 39.1 percent of lesbian and gay students report being physically harassed due to their sexual orientation (Gay, Lesbian, Straight Education Network, 2004).

Unfortunately, many times the perpetrators of violence against gay and lesbian youth are family members or community authorities. These youth are often kicked out of their homes or runaway to escape family violence (American Academy of Pediatrics, 1993). Gay and lesbian youth comprise a disproportionate share of runaway or homeless youth. One study found that of the homeless youth in Seattle, about 40 percent of them identified as gay

or lesbian, a much larger percentage of gay and lesbian youth than found in the general population (Kruks, 1991).

Domestic violence in the gay and lesbian community is a health concern where very little reliable data have been collected. Domestic violence is defined as “the systematic exercise of illegitimate power and coercive control by one partner over another” in the form of physical, sexual, emotional, or verbal abuse (Lundy, 1994). Researchers believe that rates of domestic violence between same-sex couples are roughly similar to the rates seen in heterosexual relationships (seen in about 25% to 33% of relationships) (The Medical Foundation, 1997, p. 32). Because of a positive correlation between substance abuse and domestic violence, the higher rates of substance use and abuse in the gay and lesbian community may intensify the problem of domestic violence (The Medical Foundation, 1997, p. 33).

One of the main concerns related to violence (both hate crimes and domestic violence) in the gay and lesbian community is the lack of skills, knowledge, and sensitivity of the criminal justice system in working with these problems. Many occurrences of hate crimes and domestic violence go unreported because of fear of law enforcement officials’ reaction to situations that involve sexual minorities (Dean, Martin, & Wu, 1992). This fear seems justified by research that shows that between 16 percent and 30 percent of lesbian and gay victims had also been victimized by the police (Berrill & Herek, 1990). The homophobic and heterosexist attitudes that predominate the criminal justice system have a negative impact on the reporting and resolution of violence perpetrated against the gay and lesbian community. This leaves sexual minorities at a loss for dealing with external and internal violence within their communities

Recommendations for Elimination of Health Disparities

Research regarding health disparities based on race and ethnicity is more advanced than the study of gay and lesbian health disparities. This portion of the study examines recommendations that have been made for the elimination of racial health disparities and considers their applicability for eliminating health disparities based on sexual orientation. Researchers and health professionals interested in gay and lesbian health disparities can learn from these recommendations and in some cases coordinate efforts with those organizations and individuals attempting to eliminate racial health disparities.

Consistent Data Collection

Most national household surveys and other data collection systems (e.g. hospitals, clinics, non-profit health organizations, etc.) do not include sexual orientation as a demographic variable in their data sets, nor do they

ask questions that would yield data for the different subpopulations within the lesbian and gay community. A 2002 report by the Institute of Medicine (IOM) highlighted the value of data collection: "Data on patient race, ethnicity, and primary language would allow for disentangling the factors that are associated with health care disparities, help plans to monitor performance, ensure accountability to enrolled members and payers, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices" (IOM, 2002). Data on sexual orientation would accomplish these same objectives. However, collecting data by sexual orientation presents several challenges, including:

- Defining the populations to be studied,
- Creating valid and consistent measures of sexual orientation that are representative of these definitions,
- Sampling rare and hidden populations, and
- Sampling and studying a sensitive issue (Dean, et al., 2000).

Different research studies have used different definitions of sexual orientation. Some define the term as sexual identity, others as sexual behavior, and still others as sexual attraction (Laumann, Gagnon, Michael, & Michael, 1994). In order to create measures for use in data collection, an agreed upon definition of sexual orientation must be established. While this may seem like an easy task, it is more complicated than it appears. Some men who have sex with men do not identify as gay, but have similar health concerns to those men who do identify as homosexual. Questions targeted at sexual identity may not detect individuals engaging in sexual behaviors with members of the same sex. On the other hand, if questions are targeted at sexual behaviors then the data will include a larger population than only those who identify as gay or lesbian.

Additionally, researchers must overcome methodological and financial barriers to study small subpopulations or hidden populations within the gay and lesbian community. Because gay and lesbian individuals still deal with high levels of discrimination and heterosexism on individual, societal, and institutional levels, researchers must carefully monitor all stages of their studies. "In fact, the sensitive nature of [lesbian and gay] health affects the entire research process, from the formulation of the research question, to the design and conduct of the study, to the publication and dissemination of the results" (Dean, et al., 2000, p. 137). Once these issues are addressed and measures are created, a uniform framework for collecting data on sexual orientation could be built to track data that are vital in eliminating disparities based on sexual orientation.

Enhanced Knowledge Development and Research

When the health concerns associated with racial health disparities were first acknowledged, one of the primary needs was to increase the available knowledge in the field. In order to conduct methodological and sound research, financial and societal support is needed from the government, private institutions, and the community that the research is addressing. Many of the health topics discussed in this paper are only recently being examined utilizing sound research methods. In order for research on these topics to be translatable to the broader gay and lesbian community, these studies must use random sampling processes instead of convenience sampling. Additionally, the health topics discussed previously require further efforts to advance and strengthen research on the epidemiology and risk factors related to the conditions for which disparities exist. Many organizations both in the public and private sector focus on knowledge development relating to health disparities in general. These organizations may focus on racial, ethnic, geographic, and gender disparities, but leave out disparities based on sexual orientation. If these organizations could be convinced to expand their focus of health disparities to include sexual orientation, it would be a first step towards eliminating all health disparities.

Cultural Competency Training for Health Professionals

The Healthy People 2010 report defines cultural competency as “the design, implementation, and evaluation process that accounts for special issues of select population groups (e.g., ethnic and racial, linguistic), as well as differing educational levels and physical abilities” (US DHHS, 2000). The concept of cultural competency has been used widely to depict a range of activities that advance the capacity of health systems and clinicians to deliver appropriate services to all patients. One model developed in regards to racial and ethnic diversity suggests that cultural competency training for health professionals could overcome barriers to care by:

- improving clinician/patient communication,
- increasing trust between clinicians and patients,
- creating greater knowledge of diversities among racial and ethnic groups in epidemiology and treatment efficacy, and
- enhancing understanding of patients’ cultural behaviors and environment (Brach & Fraser, 2000).

This type of training for medical clinicians could also be tailored to address health disparities based on sexual orientation. Although current studies have yet to directly link cultural competence to improved health

outcomes, the literature does indicate that strong patient-provider relationships are known to enhance patient satisfaction and a patient's willingness to access health services (IOM, 2002). An activity that increases gay and lesbian access to health care services, especially preventive services and screenings, is especially important in addressing health disparities for sexual minorities.

Furthermore, The Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project, a community-based program in Massachusetts, works "to foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for GLBT people and their families" (GLBT Health Access Project, 1999). This program has created Community Standards of Practice which provide a benchmark for providers and consumers to use in the development and exploration of culturally competent, safe, and responsive health care services. The need for these standards stemmed from findings that showed a lack of GLBT awareness and understanding among health professionals (Dean, et al., 2000). The program's efforts were guided by four principles:

1. "the elimination of discrimination on the basis of sexual orientation and gender identity;
2. the promotion and provision of full and equal access to services;
3. the elimination of stigmatization of GLBT people and their families; and
4. the creation of health service environments where it is safe for people to be "out" to their providers" (GLBT Health Access Project, 1999).

Directed by these principles, a community Working Group that included consumers, providers, and public and private agency administrators and staff created community standards of practice and quality indicators. The resulting document addresses both administrative and clinical practices, including personnel issues, client's rights, intake and assessment, service planning and delivery, confidentiality, community outreach, and health promotion (GLBT Health Access Project, 1999). These standards should be used as a guide to develop national standards for use in creating culturally competent health care services to the gay and lesbian population.

Increased Workforce Diversity

Research has shown that a lack of racial diversity among health care providers contributes to health disparities relating to health care access and the delivery of care, predominantly with respect to cultural competency. Data show that racial minority groups are underrepresented in the medical profession. Programs have been developed and are being promoted to

encourage diversity among health care professionals. Some of these activities include scholarships for minority students, loan forgiveness for those who commit to practicing in their own communities, and internship opportunities to encourage minorities to enter the medical field (McDonough, et al., 2004). While data are unavailable regarding the diversity of the medical field in regards to sexual orientation, it is logical to assume that gays and lesbians are underrepresented in this field. The same practices being used to encourage workforce diversity for racial minorities could be used to recruit more gays and lesbians to the medical professions. Encouraging sexual minorities to enter medical professions would assist in reducing cultural barriers to accessing health care services and possibly have an impact on other students attending school with sexual minorities. Additionally, the presence of more gays and lesbians in medical schools may move the medical profession, as an institution, forward in addressing its heterosexist tendencies and expanding educational training with respect to the needs and health concerns of sexual minorities.

Expanded Access to Insurance Coverage

As discussed earlier, gays and lesbians may have higher uninsured rates compared to the general population. Racial and ethnic populations are also disproportionately uninsured compared to the white population (McDonough, et al., 2004, p. 21). A 2005 article in *Health Affairs* discussed the role of health insurance in reducing racial and ethnic health disparities. This study found “evidence that a sizable share of the differences in whether a person has a regular source of care could be reduced if Hispanics and African-Americans were insured at levels comparable to those of whites” (Lillie-Blanton & Hoffman, 2005). In other words, this study found that having health insurance coverage plays a significant role in increasing access to health services which assists in reducing racial health disparities. The literature suggests ways to increase the number of racial and ethnic minorities that have health insurance by:

- expanding eligibility for Medicaid,
- expanding coverage under private health insurance (e.g. premium assistance programs),
- simplifying administrative processes to enroll in public insurance programs, and
- increasing outreach efforts to enroll individuals and families in public health insurance for which they are already eligible (McDonough, et al., 2004, p. 21-24).

Reducing racial and ethnic health disparities by expanding access to health insurance could be applied to diminish the health disparities that affect sexual minorities. The same methods for expanding insurance coverage mentioned above would also assist the portion of the gay and lesbian community that is low-income to obtain insurance coverage. However, another technique that may be even more effective in providing health insurance coverage to gays and lesbians would be to provide them access to spousal health insurance benefits through their employer. This could be done through several different policy change options. First, a law could be passed that mandates that if an employer currently offers spousal health insurance benefits to heterosexual married couples, that the employer would have to offer health benefits for the same-sex partner of an employee.

Another option would be to end the inequitable taxation of domestic partner benefits. Currently, domestic partner benefits are not equal to married benefits in the eyes of federal law. Domestic partner health insurance benefits count as taxable income for the employee. The Internal Revenue Service (IRS) has ruled that domestic partners can not be considered spouses for tax purposes. Therefore, employers are obligated to report and withhold taxes on the fair market value of the domestic partner coverage (Herrschaft, 2000). This means that if an employee makes \$40,000 a year and the domestic partner's insurance is valued at \$250 per month, that the employee will be taxed on \$43,000 at the end of the year. A married person in the same situation would only be taxed on the salary of \$40,000 (Domestic Partner Health Benefits Equity Act, 2005). Furthermore, an employer's payroll tax (the Social Security and unemployment insurance tax that an employer pays) is based on its employees' taxable incomes. When the contributions for domestic partner benefits are included in those incomes, as they are now, employers pay higher payroll taxes. In addition, this inequitable taxation places an administrative burden on the employer, who must maintain a separate payroll function for its income tax withholding and payroll tax (Domestic Partner Health Benefits Equity Act, 2005). If this inequity was removed by amending the IRS tax code, then more employers may be willing to extend domestic partner benefits to their gay and lesbian employees.

A final option would be to pass a federal law that offers gay and lesbian couples some sort of legal arrangement that recognizes their relationship. This could be through the form of civil unions or civil marriage. Once gay and lesbian couples have legal recognition of their relationships, employers would be required to offer their employees spousal health benefits if the employer currently offer these benefits for opposite-sex couples. Initiatives, programs, or policies that would expand health insurance coverage to gays and lesbians and their families would improve their access to care, which would in turn lessen the health disparities for this population.

Inclusion in State Offices of Minority Health

As of 2004, 35 states and territories had a designated office, commission, council, or advisory panel on minority health. Other states use staff in state-level departments (e.g., a state-level department of health) to manage health disparities related activities, but do not have official offices of minority health. These state minority health entities report on existing health disparities and recommend strategies and programs to eliminate these inequalities in health care. These offices often serve as the state-level contact point for government, community, and nongovernmental organization's efforts to address minority health disparities. However, no universally established standards, core competencies, or minimum infrastructure requirements exist for state offices of minority health. Additionally, "some states describe their state minority health infrastructure as a 'patchwork quilt,' where the minority health entities provide the 'essential threads' to keep different pieces of the quilt together" (McDonough, et al., 2004, p. 35).

Most state minority health offices concentrate their efforts on racial and ethnic health disparities and do not include gay and lesbian health disparities as a topic of interest. However, these offices could potentially offer valuable resources and connections to coordinate the collection of state-level data on sexual minority health disparities as well as coordinate state efforts to eliminate them. If the focus of these state entities was expanded to include gay and lesbian disparities, they could educate policymakers, health professionals, and the general public on the impact of these disparities and how oppression and discrimination affect the health of all minority groups. It also has been recommended that DHHS create an office of GLBT health that could provide overarching guidance and planning on health policy affecting this population. This office could be part of the federal Office of Minority Health which currently focuses its efforts entirely on racial and ethnic minority groups.

Prioritization of Recommendations

While all of the above recommendations would contribute to the elimination of gay and lesbian health disparities, it may be helpful and more realistic to prioritize these recommendations based on several criteria. The criteria chosen to prioritize these recommendations include:

- the potential impact of the recommendation on reducing gay and lesbian health disparities,
- the current political and social environment, and
- the ease of implementing each recommendation.

For each criterion, the recommendations were ranked from highest to lowest with the highest number being the “best” (i.e. the greatest impact, the easiest to implement, and the least controversial in the current political and social environment). The rankings for each criterion ranged from one to six. However, because the “potential impact” criterion was determined to be extremely important, this criterion was weighted by multiplying the ranking by two. The rankings and final scores are shown in Exhibit 4.

Exhibit 4. Scoring and Ranking of Recommendations

	Impact on Disparities (Weighted x 2)	Ease of Implementation	Political/ Social Environment	Score
Data Collection	(6) 12	3	4	19
Knowledge/Research	(4) 8	6	6	20
Cultural Competency	(3) 6	4	5	15
Workforce Diversity	(2) 4	1	3	8
Access to Insurance	(5) 10	5	2	17
Offices of Minority Health	(1) 2	2	1	5

The first priority (score of 20) should be to continue research on gay and lesbian health disparities to increase the knowledge in the field. This research should include both broad examinations of gay and lesbian health as well as specific health conditions affecting this population. Not only is this a vital component to reducing disparities, but research is already occurring and has become more sophisticated in recent years. Additionally, although the broader political and social environment of the country does affect research, it is a field that is relatively insulated from these factors compared to many of the other recommendations.

The collection of health data based on sexual orientation (score of 19) will not be easily implemented into United States data systems. However, data collection for the gay and lesbian population is of such vital importance that it must be one of the top priorities. Advocates, researchers, and health professionals must promote the collection of health data based on sexual orientation as a part of national surveys, health registries, hospital data systems, and other state and federal data systems. Unfortunately, resistance exists to the collection of these data due to the sensitive nature of the issues and the lack of cultural competency related to sexual minorities.

Furthermore, the current political environment makes it difficult to engage in activities that involve issues relating to the gay and lesbian population. Despite these difficulties, data collection is so critical to the understanding, and ultimately the elimination, of health disparities that it must be one of the highest priorities.

Increased access to insurance coverage (score of 17) should be the third highest priority because of the large impact that it can have on decreasing health disparities. Moreover, many of the activities currently underway to increase health insurance for racial and ethnic minorities will impact the gay and lesbian community. While the political and social environment in the United States is currently not supportive of marriage rights for the gay and lesbian population, recent surveys indicate that support for gays and lesbians having access to the legal rights and benefits of marriage is growing (Law and Civil Rights, 2006). Allowing health benefits for gay and lesbian couples would be relatively easy to implement on a national level because the United States has an employer-based health insurance system that in many cases already offers spousal benefits.

The next priority would be to increase the cultural competency of health care professionals (score of 15). While this recommendation would have a moderate impact on the elimination of health disparities, it requires an increase in the number of experts who are able to conduct cultural competency trainings as well as funding. Additionally, the recommendations concerning increased research and data collection would further reinforce the need for cultural competency training and may convince health care professionals of the need for them to seek out instruction on this topic. It will take years to implement this type of training in teaching facilities and to educate existing health care professionals on the intricacies of cultural competency regarding sexual minorities.

Increasing the diversity of the health care workforce (score of 8) in regards to sexual minorities would be the fifth highest priority. Unlike racial and ethnic disparities in the health care workforce, very little is known on this topic in regards to gay and lesbian professionals. Further research into this topic must be conducted in order to determine whether gay and lesbians are underrepresented among health professionals. If they are an underrepresented group then increasing the diversity of the workforce would have a positive impact on gay and lesbian health disparities. Unfortunately, most of the activities to increase workforce diversity require funding. For many states, as well as the federal government, current fiscal conditions make it unlikely that funding would be available for this type of program.

The final priority among the recommendations is inclusion in state offices of minority health (score of 5). While this would be an important and positive step in working to eliminate health disparities, it does not hold the same significance as the other recommendations. Furthermore, not all states currently even have an office of minority health, and many of those that do may find a political environment that is reluctant to include sexual minority health issues within an established entity. These state offices would provide helpful resources and coordination of efforts at the local level; however, inclusion in the federal Office of Minority Health should be the main priority within this recommendation.

Conclusion

The existing knowledge and understanding of gay and lesbian health disparities lags far behind that of racial and ethnic health disparities. Solid research is needed to document gay and lesbian health disparities, advance awareness among the health care community, and evaluate programs and activities to eliminate them. However, in order to further the understanding of these disparities and document the existing need, these data must be collected in a way that is culturally appropriate and respectful of this population.

Coordinating efforts with individuals and organizations working to eliminate other forms of health disparities not only makes sense from a resources perspective, but also from the standpoint of solidarity among minority groups fighting for their civil rights. Health disparities affecting any minority group should be a topic of great concern to a country that values equality and justice. Coordinating efforts to eliminate all kinds of health disparities provides these groups with a determined, formidable, and unified voice that is necessary to move health policy forward within the country's political system. Health disparities have been shown to result in higher rates of negative health outcomes for minority populations, and are therefore unacceptable.

All people should have equal access to health care and should receive quality health services that are culturally competent, respectful, and appropriate regardless of their race, ethnicity, gender, income, or sexual orientation. Disparities in health can be eliminated if a society decides that they are undesirable and designates the appropriate resources to eliminate them. Patients, health care providers, and systemic and societal factors all contribute to the problem; and therefore, must all be addressed in the work to eliminate health disparities.

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Acknowledgements

The author would like to acknowledge the assistance of Brady Baybeck, PhD, Anne Winkler, PhD, and Shirley Porterfield, PhD of the University of Missouri- St. Louis in reviewing and providing feedback on this manuscript.

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