



How to Close the LGBT Health Disparities Gap

Disparities by Race and Ethnicity

By Jeff Krehely | December 21, 2009

Introduction and summary

The original “How to Close the LGBT Health Disparities Gap” demonstrated that significant health disparities exist between lesbian, gay, bisexual, and transgender, or LGBT, and heterosexual populations. This brief will examine how health disparities for LGB people vary among different racial and ethnic groups. (The data analyzed do not include gender identity variables, so the “T” is excluded from most instances of the “LGBT” acronym in this report.) It finds that a person’s race or ethnicity and their sexual orientation are important factors for health policy researchers and advocates to consider when conducting their work.

Unfortunately, very few representative health-related surveys ask questions about a person’s sexual orientation in addition to race or ethnicity. No surveys ask similar questions about gender identity. This lack of data severely hampers efforts to design and implement programs that would best and most effectively serve all LGBT populations.

The Center for American Progress therefore calls on the U.S. Department of Health and Human Services, or HHS, to establish an Office of LGBT Health and to collect data on sexual orientation and gender identity in any federally funded health research. HHS already collects data based on race and ethnicity—adding sexual orientation and gender identity to the demographic data collected would improve our nation’s ability to serve LGBT people of all races and ethnicities.

This memo will outline LGB health disparities by race and ethnicity before discussing why these disparities occur, why we need better data on these populations, and why creating an Office of LGBT Health in the Department of Health and Human Services would be an effective way to address the problem.

LGB health disparities by race and ethnicity¹

The right-hand columns of Pages 2 and 3 present eight data points on health disparities for LGB people across different races and ethnicities.² The statistics are based on data collected through the California Health Interview Study, or CHIS. CHIS is one of the few comprehensive, ongoing state-level health survey that regularly collects information on sexual orientation. Although statistics on California’s LGB residents cannot be generalized to the national LGB population, it is useful to analyze California since it has the largest LGB population in the United States. The Williams Institute—a think tank at the UCLA School of Law dedicated to sexual orientation law and public policy—estimates that 1.3 million LGB adults live in California, representing about 15 percent of the estimated 8.8 million LGB adults in the United States.³ Unfortunately, CHIS does not currently collect data on gender identity.

Source of health disparities

The companion piece to this brief shows that the cumulative and intersecting impact of three main factors contributes to significant negative health outcomes for LGBT people: their reduced access to employer-provided health insurance, the social stigma that exists against LGBT people, and a lack of cultural competency in the health care system. For people of color, a lack of affordable health care and insurance and culturally competent service providers—along with persistent racism in society—are some of the largest causes of health disparities.¹³ An LGBT person of color faces the combined impact of these barriers, increasing the likelihood of negative health outcomes.¹⁴

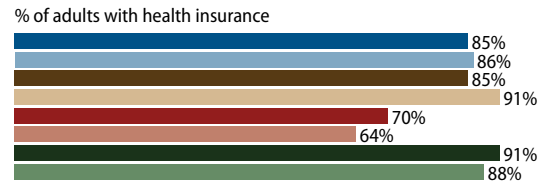
Health disparities among transgender people of color

While there is almost no data about the health disparities faced by transgender people of color, the combined impacts of racism and transphobia undoubtedly lead to worse health outcomes. The few statistics that do exist around the health disparities faced by transgender people focus almost exclusively on transgender women and incidence of HIV/AIDS.

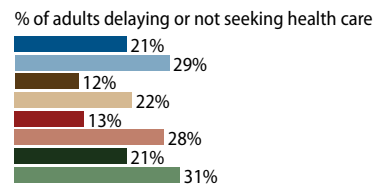
These statistics show drastically high rates of HIV/AIDS among transgender women. In California, for example, publicly funded counseling and testing sites report that transgender women have higher rates of HIV diagnosis (6 percent) than all other risk categories, including men



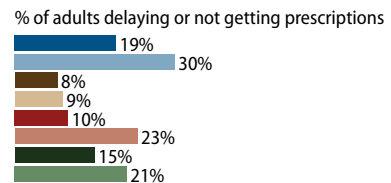
Health Disparity #1: LGB Latino adults are least likely to have health insurance.⁴



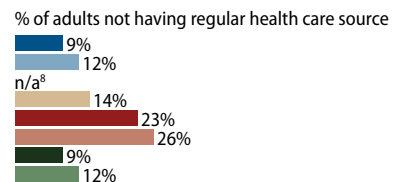
Health Disparity #2: White, African-American, and Latino LGB adults are most likely to delay or not seek health care.⁵



Health Disparity #3: LGB African-American adults are most likely to delay or not get needed prescription medicine.⁶



Health Disparity #4: LGB Latino adults are least likely to have a regular source for basic healthcare.⁷



who have sex with men (4 percent) and partners of people living with HIV (5 percent). African-American transgender women have a substantially higher rate of HIV diagnosis (29 percent) than all other racial or ethnic groups.¹⁵ In addition, according to a 2008 Minority Council report on AIDS, nearly 57 percent of all HIV-positive transgender women are African American.¹⁶ For both transgender and LGB people of color, data collection is a matter of life and death: It is impossible to improve the health and well-being of LGBT people of color without the understanding and prioritization that comes with enhanced data collection.

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We need more comprehensive data on LGBT health disparities

The CHIS statistics above are based on one of the few government public health surveys in the United States that regularly asks questions about sexual orientation. Much of the research to date on LGBT health issues has focused on sexually transmitted diseases—including HIV/AIDS—and has neglected to study other health concerns, such as the importance of mammograms for lesbians and bisexual women or how high rates of harassment affect the mental health of LGBT youth.

For example, a review of 3.8 million citations of articles in the National Library of Medicine published between 1980 and 1999 found that just 3,800 (0.1 percent) related to LGBT issues. Of these articles 2,300 (61 percent) were disease specific, with a focus on sexually transmitted diseases, mostly HIV/AIDS. Moreover, 85 percent of the articles failed to include any mention of the racial or ethnic background of the individuals studied.¹⁷

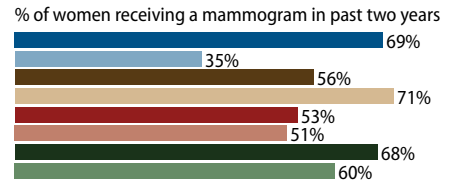
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Recommendations

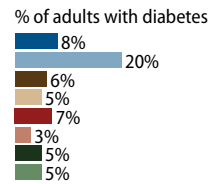
As proposed in the original “How to Close the LGBT Health Disparities Gap,” the U.S. Department of Health and Human Services should establish an Office of LGBT Health. This office would take the lead in coordinating a consistent and scientifically driven response across HHS to LGBT health disparities and overall health care for people in these populations.

The office should first act to ensure that any federally funded health study that collects demographic information—on age, sex, race, ethnicity, primary language, or socioeconomic status—must also include questions about sexual orientation and gender identity.

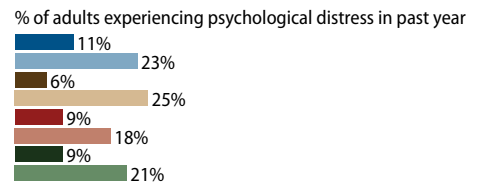
Health Disparity #5: LGB African-American women are the least likely to have had a mammogram in the past two years.⁹



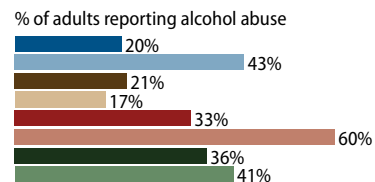
Health Disparity #6: LGB African-American adults are most likely to have diabetes.¹⁰



Health Disparity #7: LGB Asian or Pacific Islander adults are most likely to experience psychological distress.¹¹



Health Disparity #8: LGB Latino adults are much more likely to abuse alcohol.¹²



Analysis of this data should include a specific examination of the health outcomes and conditions of people based on sexual orientation, gender identity, race, and ethnicity. As the above data shows, health outcomes vary greatly by these demographic factors. To improve overall public health and to use public dollars most effectively and efficiently, the government must consider these factors when crafting public health programs and policies.

The report's author would like to thank Rebecca Fox and Kellan Baker of the National Coalition for LGBT Health for their invaluable advice and support.

Endnotes

- 1 Note that this paper uses the umbrella term “health disparities” to refer to disparities in health status and outcomes and healthcare access and quality.
- 2 Note that we presented 18 data points in “How to Close the LGBT Health Disparities Gap.” We omit 10 of the data points in this brief due to smaller samples for some of the questions or because the data did not include race or ethnicity variables.
- 3 Gary Gates, “Same-sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey” (The Williams Institute, October, 2006).
- 4 Center for American Progress analysis of 2007 California Health Interview Survey data.
- 5 Ibid.
- 6 Ibid.
- 7 Ibid.
- 8 The sample for this question was too small to generate a reliable result for this population.
- 9 Center for American Progress analysis of 2007 California Health Interview Survey data.
- 10 Ibid.
- 11 Ibid.
- 12 Ibid.
- 13 National Women’s Law Center, “Health Reform: An Opportunity to Address Health Disparities among Women” (May 2009).
- 14 See the National Coalitions for LGBT Health’s “All of the Above: LGBT People of Color” for more information on the intersection and sexual orientation, gender identity, and race and ethnicity.
- 15 California Department of Health Services, Office of AIDS, “California HIV Counseling and Testing Annual Report: January to December 2003” (2006).
- 16 Minority Council Report on AIDS, “HIV/AIDS Among Women and Girls of Color in the United States” (United States Conference on AIDS, September 2008).
- 17 Ulrike Boehmer, “Twenty Years of Public Health Research: Inclusion of Lesbian, Gay, Bisexual, and Transgender Populations,” *American Journal of Public Health* (July 2002).