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Self-rated health at the intersection of sexual identity and union status

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ABSTRACT

There is a well-established relationship between union status and health within the general population, and growing evidence of an association between sexual identity and well-being. Yet, what is unknown is whether union status stratifies health outcomes across sexual identity categories. In order to elucidate this question, we analyzed nationally representative population-based data from the National Health Interview Surveys 2013–2014 (N = 53,135) to examine variation in self-rated health by sexual partnership status (i.e., by sexual identity across union status). We further test the role of socioeconomic status and gender in these associations. Results from logistic regression models show that union status stratifies self-rated health across gay, lesbian, and heterosexual populations, albeit in different ways for men and women. Socioeconomic status does not play a major role in accounting for these differences. Findings highlight the need for specific interventions with lesbian women, who appear to experience the most strident disadvantage across union status categories.

A long-standing body research demonstrates significant union status gradients in health among the general population, wherein the heterosexual married experience advantaged health over the heterosexual cohabiting, previously-married, and in some cases the never-married at the population level (Liu and Umberson, 2008; Liu and Reczek, 2012); these advantages are stronger for men than women and in part are due to socioeconomic differentials across union status (Waite and Gallagher, 2000). A growing body of work shows that gay and lesbian identified individuals experience worse self-rated health and health behavior than heterosexuals in the United States today (Institute of Medicine, 2011). Yet, to date, the authors know of no studies examining whether a union status gradient in health extends to gay and lesbian identified adults.

We merge these two robust research areas in order to test whether union status stratifies self-rated health across heterosexual, gay, lesbian identified groups with population-based nationally representative data from the National Health Interview Survey (NHIS); this dataset is among the first datasets in the United States that allows for the comparison of self-rated health across sexual partnership status at the population-based level (Ward et al., 2013). We examine self-rated health because it is an inclusive, robust, and independent predictor of subsequent disability, mortality, and well-being; research indicates that self-rated health is an irreplaceable dimension of health status and thus is central to population health concerns (Idler and Benyamini, 1997). Identifying disparities in self-rated health at the intersection of sexual identity and union status

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(i.e., sexual partnership status) is critical for understanding health stratification among sexual minorities, particularly given recent changes in same-sex marriage laws in the U.S. Notably, research suggests that the union status gradient in the general population is in large part due to socioeconomic status differentials (Liu and Umberson, 2008). Thus, beyond testing the basic association between sexual identity and self-rated health by union status we further test the role of socioeconomic status in accounting for these associations. Moreover, a long-standing body of research shows that the relationship between union status and health is gendered (Waite and Gallagher, 2000), and that gay men and lesbian women are differentially positioned in health outcomes relative to heterosexuals and to one another (Hequembourg and Brallier, 2009; IOM, 2011; Meyer, 2003a,b); thus, we additionally test whether union status differentials in self-rated health are gendered across gay, lesbian, and heterosexual populations.

1. Previous research on sexual minority health across union status

A small but growing body of research has begun to examine whether union status gradients occur across sexual minority populations as they do across the general population. A handful of recent national, population-based studies show that same-sex cohabitors experience similar self-rated health when compared to the different-sex cohabiting and disadvantaged health relative to the different-sex married (Boehmer, 2002; Denney et al., 2013; Liu et al., 2013). In addition, recent research from state-level data in California shows that married and partnered gay, lesbian, and bisexual persons show less psychological distress than the unmarried gay, lesbian, and bisexual persons (Wight et al., 2012a,b). While these studies lay a critical foundation for the present study, significant gaps in this body of work remain.

Previous population-based studies do not compare same-sex or gay/lesbian married populations with gay/lesbian unmarried populations, missing an important group of sexual minorities that is increasing in prevalence due to changing laws in the U.S. today. Same-sex couples attain more affordable, broader access to healthcare through same-sex marriage or civil unions (Gonzales and Blewett, 2014; Hatzenbuehler et al., 2012), and thus same-sex marriage opens up pathways through which same-sex couples can achieve higher quality healthcare. Although recent state-level data suggests that, prior to national legalization of same-sex marriage, same-sex couples residing in states with legal same-sex marriage experienced better health than those in states without legal same-sex marriage (Kail et al., 2015), we are unaware of any national studies that compare lesbian or gay married individuals to lesbian or gay unmarried individuals. Other state-level studies contain data on both married and unmarried lesbian or gay individuals (e.g., Cochran and Mays, 2007; Conron et al., 2010) but to our knowledge do not make comparisons across union status. Notably, a far smaller proportion of gay and lesbian identified individuals are legally married than are heterosexual individuals due to historical restrictions on this status (Lau and Strohm, 2011; Reczek et al., 2009). Thus, there may be important compositional differences across these groups that may account for a unique relationship between self-rated health and sexual partnership status. Moreover, the existing body of population-based research does not test differences across the entire range of union statuses including the non-married. Research shows that the unpartnered experience unique health outcomes—and in fact may be advantaged in some cases (Liu and Reczek, 2012; Liu and Umberson, 2008; Urquia et al., 2013). For example, cohabitors report better self-rated health than the previously-married, but worse self-rated health than the never-married in the general population (Liu and Reczek, 2012; Williams and Umberson, 2004).

Additionally, most population-based studies have significant measurement issues in identifying gay and lesbian populations. Most rely on a household measure of being in a same-sex family structure rather than *sexual identity,* yet, the Institute of Medicine (2011) emphasizes the importance of looking at multiple dimensions of sexual orientation including identity, as household-based measures may capture couples with miscoded sex (DiBennardo and Gates, 2014; IOM, 2011; Miller and Ryan, 2011). Finally, previous population-based studies used pooled data over a decade long period in order to obtain enough sample size of sexual minorities to test differences. Yet, major changes have occurred over the past decade in terms of legal union status, and more recent data is required to fully test these differences in the contemporary U.S. today. These changes may alter who is able to legally marry and divorce in the gay and lesbian population, the stability of gay and lesbian unions, as well as differential accrual of health advantages among this population who has had uneven access to marital resources.

Taken together, these limitations prevent previous research from providing a clear consensus on the potential union status gradient among sexual minority identified individuals, nor a clear consensus on whether gay and lesbian identified individuals will have similar health as their heterosexual-identified counterparts in the same union status category. Notably, two sociological factors may play a role in these associations: Socioeconomic status (SES) and gender. We outline the potential roles of SES and gender in the relationship between partnership status and self-rated health below.

2. Socioeconomic status

Fundamental cause theory suggests that socioeconomic status is a key factor linking union status and health (Link and Phelan, 1995; Light, 2004). According to fundamental cause theory, the health disparities of gay and lesbian individuals are due, in part, to social stigma and historically unequal access to legal and institutional benefits of marriage that contribute to socioeconomic disadvantage; socioeconomic disadvantage is in turn associated with increased stress, psychological distress, and worse self-rated health (Hatzenbuehler et al., 2010; Meyer, 2003a,b). Several studies show that SES also appears to play a role in differences between same-sex cohabiting couples and their different-sex married and cohabiting