# "Like finding a unicorn": Healthcare preferences among lesbian, gay, and bisexual people in the United States

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ABSTRACT

Lesbian, gay, and bisexual (LGB) peoples' healthcare preferences are often developed in response to social and institutional factors that can ultimately deter them from care. Prior qualitative explorations of LGB healthcare preferences have been limited in their ability to identify and compare patterns across age cohort, gender, and race/ethnicity. The current study examines qualitative data from 186 modified Life Story Interviews with three age cohorts of LGB people from New York City, NY, San Francisco, CA, Tucson, AZ, and Austin, TX to understand the factors influencing LGB people's healthcare preferences. Data are analyzed using a directed content analysis approach. Five key themes emerged regarding influences on healthcare preferences: Stigma, provider expertise, identity, service type, and access. Findings suggest that healthcare preferences among LGB people are both complex and closely linked to social changes over time. Healthcare preferences among LGB people are both complex and closely linked to social changes over time.

It has been well documented that lesbian, gay, and bisexual (LGB) youth and adults are disproportionately burdened by a number of health concerns as compared to their heterosexual peers (IOM, 2011). Further exacerbating such health inequities, LGB people often face substantial barriers to healthcare, including stigma, discrimination, and harassment from medical professionals in general population venues (Butler, 2004; King and Dabelko-Schoeny, 2009; Platzer and James, 2000). A complex assortment of social and institutional factors are likely to influence preferences for care and, ultimately, healthcare utilization among LGB populations.

The Behavioral Model of Health Services Use (BMHSU; Andersen, 1995; Andersen, 2008) describes how "people's use of health services is a function of their own predisposition to use services, factors which enable or impede use, and their need for care" (Andersen, 1995, p. 1). This health utilization model has undergone a number of revisions over the years (Andersen, 1995, 2008; Andersen and Newman, 1973). Early iterations of this model were critiqued for not addressing contextual factors pertaining to the provider and healthcare environment (Aday and Awe, 1997), while more recent versions of the model have been critiqued for not providing guidance around the pathways between the

model's numerous constructs and healthcare utilization (von Lengerke et al., 2014). However, the model's broad applicability has made it a useful conceptual framework for thinking through health service utilization, making it one of the most broadly utilized models in the world (von Lengerke et al., 2014).

A systematic review of BMHSU identified age, gender/sex, and race/ethnicity as predisposing factors, health insurance as an enabling factor, and health status as a need-based factor (Babitsch et al., 2012). Applying the model to populations with unique health and social needs has required researchers to incorporate additional theoretical constructs pertaining to the issues they face (Hammond et al., 2010). Research with LGB people has illuminated a number of constructs that may similarly influence their utilization. For example, stigma plays a key role in LGB people's preferences for care (Coker et al., 2010). Past experiences with stigmatizing care or concerns about confronting stigma if one discloses a sexual minority identity may contribute to preferences for providers familiar with medical care for LGB people. The ways in which LGB people weigh issues of stigma when making decisions about healthcare utilization are not well understood, but in terms of BMHSU the presence or absence of stigma would be classified

as enabling factor situated within the social environment.

Several additional enabling factors pertaining to the healthcare system may influence healthcare preferences for LGB people. For example, Black gay and bisexual men have reported weighing both race/ethnicity and sexual identity when describing their healthcare preferences (Malebranche et al., 2004). The availability of providers of a particular gender, race/ethnicity, age, or sexual identity may also influence the types of care one is willing to seek, particularly among those with multiple marginalized identities. Within BMHSU, the demographic distribution of providers would be understood as an enabling factor associated with the healthcare system.

The healthcare venue itself is an enabling factor that may have direct implications for LGB people's healthcare preferences. LGB community health centers have historically provided great expertise in LGB healthcare, and their explicit focus on LGB people offers what many can assume will be a healthcare experience free of stigma or discrimination (Mail and Lear, 2006). However, LGB community health centers are not accessible across all parts of the United States (Martos et al., 2017). The authors highlight sharp rural/urban differences, but it can also be expected that access to LGB community health centers differs even within urban hubs based on their relative number and geographic distribution. LGB people have also indicated preferences around where they access specialized services that LGB community health centers are apt to offer, such as sexual health services (Koester et al., 2013).

As the above examples demonstrate, predisposing, enabling, and need-based factors often interact with each other, and the intricacies of these relationships can be difficult to thoroughly capture. Furthermore, studies applying BMHSU have focused predominantly on quantitative assessments of utilization as an outcome rather than on the interconnections between the factors influencing it. To that end, the current study examines qualitative data from modified Life Story Interviews (McAdams, 1995) with three different age cohorts of LGB people from New York City, NY, San Francisco, CA, Tucson, AZ, and Austin, TX to understand preferences for healthcare utilization. We define healthcare preferences as statements by participants indicating desired characteristics of their healthcare providers and venues. Within BMHSU, healthcare preferences are a predisposing factor for utilization, and we aim to understand how those preferences may be shaped by other predisposing, enabling, or need-based factors. In particular, we explore the following research questions:

1. How do LGB adults describe their preferences for LGB-specific healthcare providers and venues?
2. What predisposing, enabling, and need-based factors influence preferences for care across three age cohorts of LGB people?

# 1. Methods

## 1.1. Overview of study

This investigation is a part of a larger project known as the Generations Study ("Generations"). Generations is a multi-method study which aims to understand how the identity, minority stress, and resilience of three cohorts of LGB individuals – aged 18–25 (the "cultural inclusion" generation, or "Equality" cohort), 34–41 (the institutional advancement generation, or "Visibility" cohort), and 52–59 years (the "identity formation" generation, or "Pride" cohort) – have been influenced by changing social environments over their lifespans. These three study cohorts came of age in the United States during dramatically different social environments. For example, the Pride cohort entered into adulthood at a time when homosexuality was considered a mental disorder and sodomy was illegal in many states. LGB people in this era began early efforts to cultivate pride within their communities. The Visibility cohort entered adulthood when the HIV/AIDS epidemic was at its height and AIDS began to be treatable with effective antiretroviral therapies through a series of legal and political challenges,

while the Equality cohort entered after sodomy laws were ruled unconstitutional, the federal policy "Don't Ask, Don't Tell" was reversed by congress, and significant parts of the Defense of Marriage Act were invalidated by the Supreme Court. Public attitudes in the United States have changed across these several decades to reflect more positive views of homosexuality (Pew Research Center, 2016; Smith, 2011). Each cohort's respective labels - Equality, Visibility, and Pride – are based on hypotheses by study investigators generated following historical analyses of the periods in the United States when members of each cohort were approximately 10 years old.

It should be emphasized here that while an aim of the parent study is to determine how unique cohort experiences have shaped the lives of LGB people, the present study does not aim to distinguish between age and cohort effects. It is possible that the Equality and Visibility cohorts will have similar experiences as their study counterparts as they age, as well as it being possible that some of the findings are the result of unique experiences from the social context in which any one cohort entered adulthood. The authors will draw attention to cohort-specific findings that may pertain to unique cohort experiences but caution against interpreting any finding as more than themes and patterns in the qualitative data that may elicit additional study. The present study alone is unable to draw such firm conclusions regarding age and cohort effects.

The transgender population was excluded from Generations in order to ensure sufficient statistical power for analyses in its quantitative arm. The present study therefore focuses specifically on cisgender LGB people. However, many participants referred collectively to lesbian, gay, bisexual, and transgender (LGBT) people and health services during their interviews. For the sake of consistency within this manuscript we only use LGB unless quoting the interview protocol or participants.

While numerous additional identity labels beyond "LGB" were discussed by participants (including "homosexual," "queer," "same-gender-loving," etc.), we focus specifically on the LGB category identified by participants during recruitment and screening. For example, our sample may include asexual participants who identify romantically as lesbian, gay, or bisexual. These nuances to sexual identity are not explored within the scope of this study so as to focus on the broader patterns across self-identified LGB groups with regard to healthcare preferences.

## 1.2. Participants and recruitment

191 LGB people were recruited from within an 80-mile catchment area surrounding the New York metropolitan area, the San Francisco Bay area, in Austin, Texas, and in Tucson, Arizona. A full description of the methods for the qualitative arm of Generations, including participant recruitment strategies, are available in Frost et al. (unpublished manuscript).

Participants were eligible if they (a) self-identified as a cisgender man or woman; (b) self-identified during screening as gay, lesbian, or bisexual; (c) were ages 18–25, 34–41, or 52–59 years fitting the cohorts described above at the time of recruitment; (d) identified as Asian/Pacific Islander (API), non-Hispanic Black or African American (Black), non-Hispanic White or Caucasian (White), Hispanic/Latino, American Indian/Alaska Native (AI/AN), or Bi-/Multi-racial; (e) had been a resident of the United States since at least age 10; and (f) and completed at least fifth-grade of school. Data was collected between April 2015 and April 2016. Table 1 displays the numbers of participants recruited by gender identity, age cohort, and race/ethnicity.

## 1.3. Interview protocol

Upon enrollment, participants engaged in modified Life Story Interviews with trained study staff. Life Story Interviews involve a flexible protocol commonly used to assess identity development