



Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination



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ABSTRACT

Transgender and gender nonconforming people face stigma and discrimination from a wide variety of sources and through numerous social realms. Stigma and discrimination originating from biomedicine and health care provision may impact this group's access to primary care. Such stigma and discrimination may originate not only from direct events and past negative experiences, but also through medicine's role in providing treatments of transitioning, the development of formal diagnoses to provide access to such treatments, and the medical language used to describe this diverse group. This paper examines the postponement of primary curative care among this marginalized group of people by drawing from the National Transgender Discrimination Survey, one of the largest available datasets for this underserved group. This paper also proposes an innovative categorization system to account for differences in self-conceptualization and identity, which has been of considerable concern for transgender and gender nonconforming communities but remains underexplored in social and health research. Results suggest that experience, identity, state of transition, and disclosure of transgender or gender nonconforming status are associated with postponement due to discrimination. Other findings suggest that postponement associated with primary place of seeking care and health insurance has ties to both discrimination and affordability. These findings highlight the importance of combating stigma and discrimination generated from within or experienced at sites of biomedicine or health care provision in improving access to care for this group of people. Improving access to care for all gender variant people requires a critical evaluation of existing research practices and health care provision to ensure that care is tailored as needed to each person's perspective in relation to larger social processes.

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1. Introduction

This paper seeks to explore access to care among transgender and gender nonconforming (trans and GNC) people through a quantitative analysis of primary care postponement. Trans and GNC people face stigma and discrimination across numerous areas of life, which shapes their social experiences and realities (Bradford et al., 2013; Bauer et al., 2009). Real or perceived stigma and discrimination originating from within biomedicine and health care provision may impact this marginalized group of people's access to care (Bockting et al., 2004; Cobos and Jones, 2009). Additionally, stigma and discrimination may be experienced differently among this diverse group of people along the lines of identity, experience, and social positioning (Lombardi, 2009; Lombardi et al., 2002). Given trans and GNC people's historically uneasy relationship with biomedicine due to social stigma

originating from formal diagnoses and the barriers encountered in receiving hormones, surgeries, and other treatments of transition (Drescher et al., 2012), this group of people faces unique considerations in addressing access to primary care issues. However, newer forms of identification and organization among this group of people potentially pose new and different social relations toward health care providers and treatments of transitioning than those often described in existing medical discourse and research. The purpose of this study is two-fold: first, to define and incorporate what diversity means in this population in an adequate and comprehensive manner by introducing a new categorization scheme of difference, and second, to determine how such diversity impacts the postponement of care.

I begin by reviewing the literature on stigma, discrimination, and access to care for this group of people, and follow by describing differences among trans and GNC people along the lines of identity and experience. I then conduct regression analyses using data from the National Transgender Discrimination Survey to explore associations between these and other points of difference and

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postponement of primary curative care, including the reason provided for such postponement. Finally, I discuss implications of these findings for access to care among trans and GNC people and for health research with this group more broadly.

2. Definitions

Defining transgender has been fraught with difficulties for both trans and GNC communities and researchers alike. While early definitions usually required a gender identification “opposite” of that assigned at birth in line with transsexual conceptualizations, recent efforts also include people who simply identify as anything other than what they were assigned at birth (WPATH, 2011; Center of Excellence, 2011). As part of the study design for the data analyzed in this paper, the National Gay and Lesbian Task Force and the National Center for Transgender Equality use the terms transgender and gender nonconforming to refer to people whose gender identity or expression is different than that typically associated with their assigned sex at birth (Grant et al., 2011). This is the working definition that will be used throughout this paper. I also use the term gender variant interchangeably with trans and GNC: this includes both people who identify or live within existing sex/gender categories (i.e., as male or female) and those who identify outside of them.

Stigma has also been defined differently among researchers, with some emphasizing deviation from the norm more so than the discrimination that results from such stigma (Link and Phelan, 2001). In Link and Phelan's (2006) work on stigma and public health interventions, they propose that stigma contains several key components, including the process of labeling others via points of difference, stereotyping others through such point of difference, discriminating against and devaluing others through these stereotypes, and exercising power such that these actions and beliefs maintain substantial cultural and political hold on the lives of others. In this paper, I use stigma and discrimination together to emphasize that stigma may manifest through discrimination.

3. Stigma, discrimination, and access to care

Trans and GNC people face stigma and discrimination across numerous social realms (Bradford et al., 2013; Bauer et al., 2009). Gender variant people often experience barriers in securing stable employment, housing, education, and legal protection (Nemoto et al., 2005; Xavier et al., 2007; Monro, 2005; Kenagy, 2005). Additionally, trans and GNC people face challenges in public spaces and in accessing social services (Nemoto et al., 2005; Bauer et al., 2009). These barriers and challenges stem from the stigma and discrimination directed toward trans and GNC people from society, in which these people are socially punished for transgressing normative gender expectations based on assigned sex.

Goffman's (1963) influential work on stigma posited that stigmatization is inherently a social process in which people experience marginalization due to a perceptible point of difference that is placed onto them. Link and Phelan (2001, 2006) expand upon Goffman by bringing stigma in conversation with public health. These authors contend most research on stigma has focused on micro level interactions, such as the process of stereotyping, rather than at the macro structural level, where processes of grouping and labeling originate. Link and Phelan (2006) argue that stigma and discrimination may be experienced through three distinct forms: direct discrimination, such as the outward rejection of a group of people; structural discrimination, such as the preference for certain groups due to social organization and networks; and internal discrimination, such as the feelings and beliefs stigmatized individuals may hold toward themselves or that they recognize

others place onto them that shape their behaviors and interactions. Thus, stigma and discrimination targeted toward trans and GNC people may operate at different levels; the severity of this issue is magnified considering all of the social realms through which this may occur.

Few studies have sought to assess differences among trans and GNC people in experiencing discrimination. Lombardi (2009) found that those who transitioned under the age of 30 were more likely to experience discrimination than those who transitioned after 30. Transition was defined as the point in which the participant began presenting as male for those designated female at birth or female for those designated male. Other factors, including lower income and level of being out, were positively associated with recent experience of discrimination. In a previous study, Lombardi and co-authors (2002) found that being non-heterosexual, low income, and identifying as transsexual was associated with higher odds of experiencing economic discrimination. Furthermore, being younger, identifying as transsexual, and experiencing economic discrimination all served as predictors of experiencing violence, a form of direct discrimination. This research suggests that there may be important differences among trans and GNC people to consider in assessing discrimination.

Prior to discussing stigma and discrimination's connection to access to care, access must first be conceptualized. Levesque and co-authors' (2013) systematic review of access to care identifies five different aspects of accessibility: approachability, acceptability, availability, affordability, and appropriateness. For each case seeking care, for example, the individual must know that the service exists, must engage in social and cultural factors that shape the service and its structure (such as beliefs associated with a practice or practitioners providing the care), must be able to reach the service physically in a timely manner, must be able to afford the service, and must believe that the service fits the need. Furthermore, characteristics of the health care delivery system, characteristics of the population at hand, current health policy, type and quality of care of interest, and patient perceptions also influence issues of access (Aday and Andersen, 1974).

Existing research on access to care issues among the general population suggests that the postponement of care is associated with perceptions of limited access to care. Cunningham and Felland (2008) report that approximately 20% of the United States population did not receive or delayed seeking needed medical care in 2007, with this figure having steadily increased since 2003. The CDC estimated that 9% of the United States population delayed seeking needed medical care in the year 2008 due to cost alone (Adams et al., 2009). Those with the worst health conditions were more likely to delay seeking care than those with the best health conditions, further exacerbating health disparities (Adams et al., 2009; Diamant et al., 2004). Additionally, perceptions of poor access to medical care are correlated with higher rates of hospitalizations, and difficulties in receiving care have been suggested to contribute to deterioration in health (Bindman et al., 1995). Other research suggests that patient trust that a physician will act in the patient's best interest and patient delay in seeking needed care are inversely related (Mollborn et al., 2005).

These issues are of considerable importance for trans and GNC people and their experiences. Difficulties in accessing treatments of transitioning (i.e., hormones or surgery) have created the perception of providers as gate-keepers among trans and GNC people (Bockting et al., 2004; Cobos and Jones, 2009). The process through which people must engage with medical systems in order to modify their bodies has been critiqued as undermining trans and GNC people's own autonomy, and more recent efforts have sought to set forth newer models of accessing this form of care (WPATH, 2011; ICATH, n.d.). However, others have argued that formal diagnoses

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