NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

00-10

STATEMENT OF POLICY

LGBTQ Health

Policy

The National Association of County and City Health Officials (NACCHO) supports the incorporation and adoption of principles of social justice into social policy, public health curricula, workforce development initiatives, and the design of program evaluation measures as strategies to eliminate health inequities. Based on those principles, NACCHO encourages local health departments to act on the social injustices at the root of health inequities impacting lesbian, gay, bisexual, transgender, and queer (LGBTQ)[1] individuals, families, and communities and honor diverse sexual orientations, gender identities, and gender expressions. This work includes promoting the rights and health of LGBTQ communities through policies and practices that protect against discrimination and by offering culturally competent health services. NACCHO encourages local health departments to take the following actions to help eliminate health inequities, oppression and discrimination against LGBTQ individuals, families, and communities:

- Collect, track, and regularly publicize sexual orientation and gender identity (SOGI) data, and develop, track, and regularly publicize indicators that measure the health and well-being of LGBTQ populations, including inequities in health status.
- Ensure health department programs and services are inclusive and affirming of LGBTQ individuals, families, and communities. This includes, but is not limited to, providing training to health department staff to promote structural and cultural competence and ensure data on sexual orientation and gender identity are collected in an affirming, nonjudgmental manner; adapting forms, paperwork, curricula, and other outreach and educational materials to be more inclusive and/or gender-affirming; and train providers on the importance of inquiring about sexual orientation and gender identity in an affirming matter in order to provide appropriate and indicated medical care.
- Educate other local government agencies, community-based organizations, healthcare providers, schools, and other stakeholders about health inequities and discrimination experienced by LGBTQ individuals, families, and communities and support them in developing and implementing strategies to ensure programs and services are LGBTQ-affirming.
- Develop and implement programs at the local level designed specifically to address inequities in health status among LGBTQ individuals, families, and communities.
- Advocate for policies and ordinances at federal, state, and local levels that are inclusive of sexual orientation and gender identity and expression and prohibit all discrimination on the basis of sexual orientation and gender identity and expression.[2-3]
- Advocate for the continued development by the Department of Health and Human Services (HHS) and other governmental agencies of an expanded research agenda on

LGBTQ health, and, based on evidence to date, start implementing changes to service delivery and health care access based on issues already identified.

Justification

State of health among LGBTQ populations

In 2016, approximately 887,000 same-sex households were reported in the U.S. Census Bureau's American Community Survey.[4] Approximately 4.5% of the U.S. population identifies as lesbian, gay, bisexual, or transgender.[5] Despite progress in the advancement of civil rights for some LGBTQ populations, members of the LGBTQ community continue to experience social exclusion, isolation, discrimination, injustice, and worse health outcomes than their cisgender, heterosexual counterparts. In examining the health of LGBTQ populations relative to cisgender and heterosexual individuals, health inequities emerge from the intersection of fundamental injustices overlapping with race, class, and gender oppression.

Inadequate Data on LGBTQ Health

Over the past decade, significant progress has been made in addressing the dearth of research on the health of LGBTQ communities. HHS has added questions regarding sexual orientation, gender identity, and/or same-sex households to several large, nationally-representative surveys, including the Behavioral Risk Factor Surveillance System, the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Youth Risk Behavioral Surveillance System.[6]

There continue to be challenges in ensuring that language and data classification used in public health surveillance are not reflective of discrimination. The sexual orientation and gender identity (SOGI) modules tend to be optional; the BRFSS's optional gender identity module was used by only 19 states and 1 territory in the 2014 survey.[7] In clinical settings and research, trans and gender non-conforming people are frequently misclassified, as electronic health records (EHRs) often don't have comprehensive sexual orientation and gender identity categories. Additionally, clinicians may not be trained to collect this information in a culturally competent manner. While the gender of sexual partners is often used as a proxy indicator for sexual orientation, less than half of patient records include these data, despite patients reporting overwhelming support and recognition of the importance of questions regarding sexual orientation and gender identity.[8-9] In addition to these gaps, there are challenges with comparability of data, as the constructs and language used to measure sexual orientation and gender identity are not always consistent. Additionally, much of the evidence base conflates sexual orientations and/or gender identities. For example, many studies compare heterosexual participants with lesbian, gay, and/or bisexual participants, obscuring the distinct experiences of lesbian, gay, and bisexual individuals. Data-driven health systems therefore render whole communities invisible in decision-making processes, hampering efforts to create strategies that would best serve all LGBTQ populations. Public health practitioners, health officials, and researchers need more demographic data and data on the appropriate health indicators for the development of programs that reduce inequities and improve the health of LGBTQ individuals.

Health Inequities and Discrimination

Youth Populations: Despite these gaps and limitations, existing research and data on LGBTQ health reveal significant health inequities across the lifespan. According to the Youth Risk

Behavior Surveillance System (which does not ask about gender identity consistently), lesbian, gay, and bisexual (LGB) high school students are more likely to engage in behaviors that put them at risk for HIV, STIs, and unintended pregnancy, and experience high rates of negative sexual, mental, and behavioral health outcomes.[10] LGB youth are more likely to initiate sexual activity before age 13, less likely to use protection, and more likely to have had sex and to have had at least four sexual partners.[11] More than 80 percent of HIV diagnoses among youth aged 13 to 24 occur among gay and bisexual men and lesbian, gay, and bisexual students report higher rates of pregnancy.[12,13] These trends are likely due to stigma, discrimination, and inequitable access to relevant sexual health information and culturally-competent health care.

Compared to heterosexual students, LGB students are almost twice as likely to experience bullying (33% for LGB students and 17.1% for heterosexual students) and to be threatened or injured with a weapon on school property (9.4 and 5.4%, respectively). Consequently, 10 percent of LGB students report missing a day of school due to safety concerns in the past 30 days, compared to 6.1% of heterosexual students. LGB students are more likely to report feeling sad or hopeless (63% of LGB students compared to 27.5% of heterosexual students) suicidal thoughts (47.7 and 13.3%, respectively) substance use, and sexual and relationship violence (22.2 and 7.9%, respectively for sexual violence; 17.2 and 6.4%, respectively for physical dating violence.

Similarly, transgender youth experience disparities in violence victimization, substance use, suicide risk, and sexual risk compared with their cisgender peers; 23.8% of transgender students reported ever being forced to have sexual intercourse, and 26.4% experienced dating violence.[14] A higher percentage of transgender students report using substances; critically, the use of high-risk substances, such as cocaine, heroin, methamphetamine, and prescription opioid misuse, is higher among transgender youth than cisgender youth.[15] Transgender students are also at greater risk for suicide and report higher rates of sexual risk behaviors, including drinking or using drugs before sex and not using condoms.

Health inequities may be even greater for out-of-school LGBTQ youth. Forty percent of homeless youth identify as lesbian, gay, bisexual, or trans, and nearly half report that they either ran away (46%) and/or were forced out (43%) due to their sexual orientation or gender identity.[16] LGBTQ youth, particularly LGBTQ youth of color, are disproportionately impacted by the school-to-prison pipeline, reporting elevated rates of school discipline and absenteeism—a trend further exacerbated in schools with discriminatory policies and practices or where LGBTQ students report hostile school climates.[17] LGBTQ students also report involvement with the criminal justice system as a direct result of school discipline and absenteeism.[18]

Adult Populations: These stark inequities in mental, behavioral, and sexual health outcomes for LGBTQ individuals persist throughout adulthood. LGBTQ individuals are three times more likely than heterosexual individuals to experience mental health conditions such as depression and anxiety and twice as likely to report using illicit drugs or misusing prescription pain relievers in the past year.[19,20] Overall, transgender individuals experience greater psychological distress than the general population, which should be understood in the context of oppression and discrimination. Thirty-four percent of transgender adults reported ever having suicidal thoughts as compared to 10% of cisgender adults and were more than six times as likely to have ever attempted suicide (22% vs. 4%). They were nearly four times as likely to have experienced

significant psychological distress in the past year (33% vs. 9%).[21] Transgender respondents were more likely to rate their health as fair or poor as compared to cisgender respondents. However, the analysis did not find broad disparities on many health outcomes or health behaviors, suggesting that when discussing the health of transgender populations, there are both areas of vulnerability as well as resiliency.

All LGBTQ individuals, particularly queer and trans people of color, are also at greater risk for HIV and other sexually transmitted infections (STIs). In 2016, men who have sex with men (MSM) accounted for two-thirds of HIV cases in the United States, and while many demographic groups are experiencing declines in HIV incidence, rates remain stable for Black MSM and are increasing for Hispanic/Latino and Asian-American MSM.[22,23] While information on sexual partner(s) of STI patients is not always collected and/or reported to CDC, MSM accounted for an estimated two-thirds of syphilis cases in 2017 and gonorrhea incidence increased among MSM by 151% between 2010 and 2015 (compared to 40% for women and 32% for men who have sex with women).[24] Inquiring about sexual orientation and gender identity, in addition to sex practices, is necessary to ensure that patients receive appropriate and indicated care, such as extragenital STI testing and cervical cancer screenings.

These inequities are often exacerbated within subsets of the LGBTQ population, including LGBTQ people of color, elderly LGBTQ persons, and bisexual and transgender individuals. Elderly LGBTQ individuals face additional barriers to accessing healthcare and elevated health risks due to social isolation and a lack of social services and culturally competent providers.[25] Older LGBTQ adults, in particular bisexual and transgender adults, are more likely to live at or below 200 percent of the federal poverty level compared to older heterosexual adults.[26] While stigma, discrimination, and social isolation may contribute to negative sexual health outcomes in older LGBTQ adults, strong social support and large networks are associated with lower risk of depression, disability, and poor general health.[27]

These health inequities are compounded by the dearth of LGBTQ-competent healthcare providers and lower rates of insurance coverage and healthcare access; transgender individuals are less likely to have insurance coverage or a primary care provider.[28] Homophobia and transphobia contribute to stigma and discrimination against LGBTQ persons, including in health care settings. In separate studies, more than half of lesbian, gay, and bisexual individuals and nearly 40% of trans individuals reported being denied care or mistreated by a healthcare provider.[29] Accessing healthcare as a transgender individual can be a serious challenge in a healthcare landscape that is characterized by a lack of trans-competent healthcare providers and limited insurance coverage for transition-related care. Transgender individuals often opt not to tell providers that they are transgender and face negative healthcare experiences, which may include having to teach providers about being transgender in order to receive appropriate care (24%), and being asked invasive or unnecessary questions about being transgender not related to the reason for the visit (15%).[30] Not all transgender people want or need healthcare related to gender transition, but many do, and treatments may include counseling, hormone therapy, and surgical procedures. Transition-related healthcare needed by transgender individuals is too often denied by insurance plans, both public and private. According to the 2016 US Transgender Survey, in the past year, 25% of respondents who sought insurance coverage for hormones were denied, and 55% of those who sought coverage for gender affirming surgery were denied.[31]

Policy Landscape for LGBTQ rights

In 2015, a landmark Supreme Court case, *Obergefell v. Hodges*, ruled that states could not ban same-sex marriage, legalizing same-sex marriage in all 50 states and D.C. and requiring states to recognize out-of-state same-sex marriage licenses.[32] Beyond marriage equality, the federal government has not taken sufficient action to promote and protect the rights of LGBTQ Americans, resulting in a patchwork of state and local laws and court rulings. Nearly half of LGBTQ Americans live in states where employers and schools can legally discriminate against them on the basis of their sexual orientation or gender identity and more than a quarter of LGBTQ Americans live in states that either do not have hate crime laws or where hate crime laws do not cover sexual orientation and/or gender identity.[33,34,35]

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 has had a significant impact on access to health insurance in the United States, including for LGBTQ populations, by expanding Medicaid; offering health insurance—and subsidies for low-income Americans—through federal and state health insurance marketplaces; prohibiting discrimination in insurance provision, including against people with pre-existing conditions and on the bases of sexual orientation and gender identity; and requiring data collection and surveillance on health inequities. Consequently, uninsured rates among lesbian, gay, and bisexual adults dropped nearly in half, from 19% in 2013 to 10% in 2016.[36] However, many LGBTQ Americans continue to experience discrimination in healthcare, including by healthcare providers. More than half of LGB and 70 percent of transgender and nonconforming Americans report either being refused care, blamed for their health status, or having a healthcare provider refuse to touch them or be verbally or physical abusive.[37]

Without sufficient federal protections for LGBTQ rights, federal, state, and local leaders play an outsized role in influencing the landscape of discrimination in their jurisdictions. Under the Trump Administration, many federal agencies have contributed to or directly discriminated against LGBTQ Americans. For example, openly transgender individuals are now banned from serving in the U.S. military; the Department of Housing and Urban Development no longer protects LGBTQ Americans from housing discrimination; the Department of Education no longer protects transgender students who are banned from using a bathroom that aligns with their gender identity; and the Department of Justice has been involved in several legal decisions that limit LGBTQ rights.[38] In May 2019, the Department of Health and Human Services proposed a new regulation that allows healthcare providers to deny services to their patients on the basis of their religious beliefs, which could allow providers to refuse to provide care to LGBTQ Americans.[39] These executive actions demonstrate the importance of federal protections for LGBTQ Americans, and the significant role the federal government can play in either protecting against or contributing to discrimination.

Impact of Social Injustice on LGBTQ Communities, Individuals, and Families

Discrimination and institutionalized injustice at all levels and in areas of life create unjust barriers to healthy living for historically marginalized communities. These injustices pose serious

consequences and extract great social costs by limiting people's ability to access needed resources and to live healthy, whole lives. A lack of recognition by researchers and a limited research base, the denial of basic civil rights, barriers to inclusive medical care and equitable wages, and the threat of violence all conspire to exclude LGBTQ individuals from decision-making and limit their ability to experience what most individuals take for granted. Importantly, injustices also expose people to risks that in turn predispose individuals to disease and death.[40] Over the life-course, the impact of social injustice on health accumulates and grows worse, devastating LGBTQ communities.[41]

References/Notes

1. The acronym LGBTQ is intended to describe people who don't identify as cisgender and/or heterosexual. (Cisgender is defined as denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.) The term LGBTQ provides a way to talk about people who experience oppression because of their sexual orientation and/or gender identity, without referring to them in relation to cisgender and heterosexual people. (For example, referring to LGBTQ people as *not* heterosexual and/or *not* cisgender treats them as something other than the norm.) However, the term LGBTQ conflates sexual orientation and gender identity, and belies the distinction between the two. While sexual orientation characterizes whether and to whom someone is romantically or sexually attracted, gender identity refers to a person's sense of their gender, which may or may not be the same as the sex that they were assigned at birth. The acronym itself is not comprehensive, and other variations of the acronym include questioning, intersex, asexual, pansexual, genderqueer, non-binary, and/or two spirit. For the purpose of this policy statement, we use LGBTQ to refer not just to lesbian, gay, bisexual, transgender, and queer persons, but to all persons who experience oppression and discrimination on the basis of their sexual orientation and/or gender identity. While oppression and discrimination manifests differently based on one's sexual orientation and gender identity, much of the evidence base on associated health inequities is not sufficiently disaggregated into separate sexual orientations and/or gender identities, and consequently we are not able to fully characterize these distinctions.
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Record of Action

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