LGBTI PEOPLE AND HEALTH INEQUALITIES

> **#EHFG2018** – Forum 12: Sustainable strategies for addressing health inequalities

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Summary: Lesbian, Gay, Bisexual, Trans, and Intersex (LGBTI) people commonly experience a range of health and social inequalities. Such inequalities are unfair, preventable and fundamentally incompatible with public health and human rights principles. This article draws on the European Commission's Health4LGBTI pilot to highlight some of the inequalities faced by LGBTI people in EU Member States, as well as their fundamental causes in relation to health services. In doing so, we propose that mandatory training for health professionals needs to be considered as one of the main interventional avenues towards reducing the health inequalities experienced by LGBTI people.

Keywords: *Health Inequalities, LGBTI People, Access to Health, Health Professionals, Training*

Introduction

"I had …a child psychiatry course. And I was… given a book. I was told: "Read it, it is our Bible". In this text book there was a description of homosexuality... It stated that it is a disease. It is a book from Soviet times and at the moment medical students still use it to study and consult teenagers brought to the crisis intervention unit." – quote from LGBTI person from Lithuania.[1]

Across the European Union (EU) life expectancy has been improving over the years. Yet despite this positive gain, considerable health inequalities continue to persist both between and within European Member States. Health inequalities refer to the avoidable differences in health status between particular groups, populations or individuals. They result from social inequalities, the differences in the conditions in which people are born, grow, live, work, and age.[2] Health inequalities are fundamentally unjust or unfair because they are a consequence of a combination of factors such as the actions and policies of governments, social and cultural norms, as well as diverse socio-economic circumstances. This means that inequalities go against the principles of social justice in public health (e.g. fair and equitable treatment of people, and preventing disease, prolonging life, and improving the health of all populations). They are also fundamentally incompatible

Box 1: Defining LGBTI

L – Lesbian refers to a woman who is emotionally and/or sexually attracted to other women.

G – Gay refers to a person who is sexually and/or emotionally attracted to people of the same gender. It traditionally refers to men, but other people who are attracted to the same gender or multiple genders may also define themselves as gay.

B – Bisexual person is a person who is emotionally and/or sexually attracted to people of more than one gender.

T – Trans person is an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant, gender non-conforming or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity.

I – Intersex individuals are born with physical sex characteristics that don't fit medical or social norms for female or male bodies. These variations in sex characteristics may manifest themselves in primary characteristics (such as the inner and outer genitalia, the chromosomal and hormonal structure) and/or secondary characteristics (such as muscle mass, hair distribution and stature).

Source: [3]

with the 2030 Sustainable Development Goals (SDGs; for instance, SDGs 3 and 10 – ensure health and wellbeing for all at every stage of life, and reducing inequality within and among countries), and its commitment to 'leave no one behind' as well as essential EU values reflected in the Charter of Fundamental Rights and Article 168 of the Treaty on the Functioning of the European Union (TFEU) on the protection of public health.

There is a now a large, weighty, and growing body of literature that describes health inequalities experienced by different groups and populations. In terms of lesbian, gay, bisexual, trans and intersex (LGBTI – **see Box 1**) people, this body of literature is relatively substantial (albeit unbalanced in its lack of focus on the individual groupings) showing that, in general, LGBTI people experience considerably worse physical and mental health outcomes than the general population.[4] For example, with regards to physical health the literature demonstrates that LGB people are at higher risk of developing certain types of cancer and at a younger age compared to heterosexual people.[5] In terms of mental health, LGBTI people are at significantly higher risk of experiencing mental distress with LGB people being two to three times more likely to report an enduring psychological or emotional problem including suicidal ideation and suicide, substance misuse, and deliberate self-harm compared to the general population.

The social determinants of health inequalities experienced by LGBTI people such as stigma, discrimination in health care, social exclusion, and **heteronormativity** are well-recognised root causes of these poorer health outcomes.[6] Indeed, in relation to health systems, barriers to the delivery of, and access to, health care and health systems for LGBTI people can partially account for inequalities and commonly include prejudicial attitudes and discriminatory behaviour by health care staff, unequal treatment, and unrecognised health care needs. Although by no means a panacea, universal access to safe, high quality, efficient health services and better cooperation between social and health care services with effective action on risk factors, can all help in the efforts towards reducing inequalities for LGBTI people (as well as other populations).[7] One way of contributing to such efforts is through the provision of mandatory high-quality training for health care (and other relevant) staff with regard to the needs of LGBTI people, to provide health professionals with the ability to challenge anti-LGBTI attitudes and practices amongst colleagues and patients; something that can be very difficult to do.

The European Commission is taking the battle against health inequalities seriously. As part of the Commission's commitment to work towards the UN Agenda 2030 SDGs both inequalities and health are specifically addressed. Furthermore, funded by the European Parliament and managed by a European Partnership on behalf of the European Commission's Directorate-General Health and Food Safety, this commitment is evident in the commissioning of a recent pilot project 'Health4LGBTI: Reducing health inequalities experienced by LGBTI people' (**see Box 2**).

Root causes of LGBTI health inequalities

"Stigma, prejudice, and discrimination create a hostile environment where LGBTI people are subject to stressful social exchange that may have adverse implications for health-seeking behaviour and health outcomes later in life."[6]

Health inequalities result from a complex interaction of environmental, social, cultural and political factors. The research findings of the Health4LGBTI project elicited a number of these overlapping root causes likely to contribute to the experience of health inequalities by LGBTI people including: cultural and social norms that preference and prioritise heterosexuality (**heteronormativity**); **minority stress** associated with sexual orientation, gender identity and sex characteristics; victimisation; discrimination (individual and institutional); and stigma. Each of these are addressed briefly below in relation to health(care):

Health inequalities can occur in contexts (e.g. hospitals, GP surgeries etc) where heteronormativity is at play. It can be defined as a set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. In mainstream health care

Box 2: Health4LGBTI – Reducing health inequalities experienced by LGBTI people

The aim of this pilot project (2016–2018) was to improve the understanding of how best to reduce health inequalities experienced by LGBTI people. The project activities included (i) Research into health needs and challenges faced by LGBTI people and key barriers faced by health professionals when providing care for LGBTI people; (ii) Development of a training package aimed at increasing the knowledge, attitudes and skills of health care professionals when providing health care to LGBTI people; (iii) Piloting of the training package in six EU countries (Belgium, Bulgaria, Italy, Lithuania, Poland and UK); and (iv) A European conference presenting the results of the project.[8]

Further information: For details on Health4LGBTI, including full and free access to the research reports, training modules, and evaluation report see: https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2

settings where LGBTI people access treatment and care, being heterosexual, cisgender* or dyadic (non-intersex) is often assumed and accepted as the status quo. LGBTI people consequently become marginalised due to health professionals failing to recognise their lives, their gender, their bodies, their relationships and their families, meaning that needs are overlooked, and care is affected. Moreover, it also means that LGBTI people who do access health care and other support services may be less likely to be open and disclose their sexual orientation, gender identities or sex characteristics, and/or information relevant to their specific needs.

With regard to **minority stress** (one of the leading narratives explaining health inequalities experienced by LGBTI people), researchers explain that stigma, prejudice, and discrimination create a hostile environment where people are subject to stressful social exchange. Population groups who experience minority stress often show a greater incidence of mental health problems that eventually lead to poor physical health.[9]

Victimisation also appears to be a root cause of inequalities faced by LGBTI people and is commonly experienced as a direct consequence of their sexual orientation, gender identity, and/or sex characteristics. Katz-Wise and Hyde conducted a meta-analysis and found that accounts of self-reported victimisation of LGB individuals were substantial with 55% experiencing verbal harassment, 45% experiencing sexual harassment, 44% experiencing relational victimisation, and 43% general victimisation.[10]

In terms of **discrimination**, evidence shows that most LGBT people have experienced individual and institutional discrimination at some point in their lives. Individually, this ranges from hostility, personal rejection, harassment, bullying, to personal violence.[11] Institutionally, this occurs where laws and policies in the public domain generate and/or sustain inequalities, for example when rainbow families are not recognised or where laws do not protect against discrimination based on sexual orientation, gender identity or sex characteristics.

Finally, overlapping with many of the above root causes, **stigma** also emerged as one of the leading causes of LGBTI health inequalities. Stigma comprises three different but related elements: anticipated stigma where LGBTI people show apprehension due to potential future occurrences of stigmatisation; internalised stigma where people devalue themselves as a result of their sexual orientation, gender identity or sex characteristics; and enacted stigma where people experience real instances of discrimination. Each strand of stigma may affect health-seeking behaviour in a specific way (e.g. inhibiting disclosure of same-sex relationships or sex characteristics) ultimately shaping access to health care amongst LGBT people.[12]

"I once went for a stomach check-up and the GP asked me whether I had done an HIV test. He told me I should go to do it without even asking me whether I was promiscuous or not – I could have been a virgin." – Gay man, Malta.[13]

Taking action for LGBTI people

LGBTI people in Europe experience significant health and social inequalities and these are often avoidable and thus preventable. Health policies and programmes need to be reviewed and reformed so that they fully reflect and mainstream the health needs of LGBTI people. In the short term, we believe that inequalities can be reduced via the development of health and social care services that are sensitive to the needs of LGBTI people as much as they are already attuned for non-LGBTI people.

> fundamentally incompatible with the 2030 Sustainable Development Goals

Reducing preventable inequalities for LGBTI people is not only morally the right thing to do, but it is essential action in line with European efforts to meet the SDGs, to abolish discrimination on any grounds and to uphold and promote the human rights of LGBTI people. To this end, Health4LGBTI has developed a freely available and validated training programme aimed at increasing the knowledge, attitudes and skills of health professionals when providing health care to LGBTI people in an attempt to address some of the root causes of inequalities (**see Box 2**). Evaluative data

* Cisgender (adj.): A term referring to those people whose gender identity matches the sex they were assigned at birth.

from piloting in six EU countries has shown promising results; with increases in culturally competent knowledge and skills, attitudinal change, and changes in both day-to-day practices as well as relevant and necessary changes within health systems (e.g. recording mechanisms).

There is much to be done to ensure that both specialist and universal health services are truly inclusive and equally accessible to all regardless of gender identity, sexual orientation, or sex characteristics. Engaging with health professionals around LGBTI issues is a crucial step in the process to remove barriers, improve inclusivity, improve care, and ultimately reduce inequalities.

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