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“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.

Keywords

United States; Healthcare access; Lesbian; Gay; And bisexual health

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

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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 anti-retroviral 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 through a constructed life-story narrative. The protocol was adapted to include questions about sexual identity development, same-sex awareness and experiences, minority stress experiences, and participants' experiences with healthcare utilization. The healthcare utilization portion of the interview included several core questions surrounding participants' most recent experiences utilizing physical and mental health services, disclosure of sexual identity with healthcare professionals, and perceived importance of LGB-specific healthcare venues or providers. The qualitative interview protocol is available in Frost et al. (unpublished manuscript).

1.4. Data analysis

Interview recordings were transcribed by a professional transcription service and uploaded to the qualitative data software Dedoose 7.5.6. The first author began by segmenting and extracting the section of each interview pertaining to healthcare utilization, which was then analyzed using a directed content analysis approach. In this approach, predetermined frameworks and theories generate coding schemes for analyzing qualitative data (Hsieh & Shannon, 2005). The extracted segments were then reviewed and memoed by the first author, from which an initial codebook was drafted specific to the aims for the present study. Consistent with a directed content analysis approach, codes were based initially upon prior formative research conducted as a part of the broader parent study and the core health questions within the interview protocol. Codes were adapted as-needed according to the reviewing and memoing conducted during of codebook development. For example, the first author initially identified "Access and Utilization" as a potential code based on it being a significant topic that emerged in the formative research phase and its inclusion as a topic within the interview protocol. Through ongoing meetings with the co-authors it was collectively decided to break these into separate codes for "Healthcare Access" and "Utilization Experience." Co-authors later agreed add sub-codes to the Healthcare Access code in order to distinguish between barriers and facilitators.

Final codes include: Provider and venue selection (with the sub-codes "Provider preferences" and "Venue preferences."); LGB health services and care; Utilization experience; Healthcare access (with the sub-codes "Barriers to healthcare" and "Facilitators to healthcare."); Health status; and motives for seeking or avoiding care (with the sub-codes "Motives for seeking care" and "Motives for avoiding care."). All co-authors reviewed, edited, and finalized the codebook together, and the first author then began coding each of the healthcare utilization segments.

All excerpts coded with either of the sub-codes "Provider preferences" or "Venue preferences" were extracted and analyzed through the lens of BMHSU. In other words, the authors sought out the pre-disposing, enabling, and need-based factors influencing provider and venue preferences among LGB people. All co-authors met to analyze the data and review findings. During these meetings any differing interpretations were discussed until consensus on findings was achieved. Five participants were unable to complete the

healthcare section of the interviews, and so the data presented reflects a total of 186 participants.

2. Results

Explanations for LGB healthcare preferences centered around five key themes: Stigma, expertise, identity, service type, and access. Expertise, identity, and service type were frequently intertwined in relation to participants' preferences, and are presented together in order to reflect this complexity. Sample quotes encapsulating the dominant narratives within each of these themes are available in Table 2. The groups that most consistently endorsed the dominant narratives are also included but should not be interpreted as experiences exclusive to that group. Due to age cohort being a core organizing structure of the parent study and study sample, key differences across the Pride, Visibility, and Equality cohorts are highlighted where appropriate. Gender differences also emerged quite often and are highlighted frequently in the findings below, with race/ethnicity or experiential differences (e.g., relationship and/or family structure) noted where relevant to the themes and patterns that emerged. Each should be understood as other predisposing factors within the BMHSU model influencing healthcare preferences.

Each of the themes and their dominant narratives are presented in greater detail below. A small number of participants also offered unique or counter narratives which, while not often repeated by others in the context of this study, demonstrate the complexity of healthcare preferences and the factors influencing them; these unique or counter narratives are also shown in Table 2, when applicable. The results that follow further illustrate the ways participants within each cohort frame their healthcare preferences and underscore the varied considerations LGB people take into account when seeking health care.

2.1. Stigma

Stigma was one of the most frequently discussed factors related to healthcare preferences. For our analysis, stigma was defined as real or perceived negative social attitudes directed toward participants about one or more of their identities. Across all three cohorts, stigma most consistently influenced participants' communication with providers and was often associated with their preferences for LGB-specific providers and venues, particularly among male participants. In the Equality cohort, most consistently among Black men, several participants discussed the significance of their own comfort communicating openly and honestly with LGB-specific providers. As one 21 year-old Black participant from Austin explained: "Yes, [an LGB provider] would make a difference. That would be awesome actually. If that was the case, just being more open. And you'll get – it will be more authentic for me in a sense." Men in the Visibility cohort, on the other hand, often expressed concern for providers' comfort levels in addition to their own. One 36 year-old White participant from the San Francisco area described his preference for LGB physicians: "For that ease of conversation. I prefer not to have any hang-ups when it comes to my health because I don't want [that] to get in the way for me getting better from something. I don't wanna have my time wasted by uncomfortably navigating people that may or may not be at ease with it."

In the Pride cohort, men related the possibility of stigma to a desire for LGB-specific or LGB-friendly providers (i.e., practitioners who do not identify as LGB but are accepting and affirming of LGB patients), but emphasized a preference for men over women practitioners. White and Latino men often specified gay men as their preferred providers. However, regardless of the specific preference indicated, men in the Pride cohort, like men in the Visibility and Equality cohorts, based their preferences on a need to be comfortable discussing their sexuality. One 53 year-old White man from New York explained that, if he was unable to speak frankly to his doctor about his sexual activity with other men, they might not be comfortable addressing any subsequent health issues together. “I don’t wanna be embarrassed, or have a doctor blush or run outta the room because I said last night I was penetrated anally, or last night I swallowed some semen. I don’t want that cuz it’s about me, when I’m there.” Being comfortable enough to speak openly with a provider was often associated with confidence in the quality of services they were receiving.

Several women in the Visibility cohort described steps for identifying providers with whom they were least likely to experience stigma. One 36 year-old Bi-/Multi-racial participant from the Tucson area described a variety of strategies she took to identify her provider, including online searches, resources from LGB community-based organizations, and word of mouth: “I look at other websites. Sometimes it’s a pain in the ass. You have to cross-list for insurance with these other LGBT-friendly providers. I would use Wingspan’s resource guide or other queer resource guides about providers and who is good, or I’ll ask my friends. Like, ‘Hey, who do you see?’” Other women described using online community forums, or calling into providers’ offices to ask directly if they have experience with or are comfortable providing care to LGB patients. At times these efforts resulted in identifying an LGB-specific provider, and other times LGB-friendly ones, but most important was determining in advance that the provider would not treat them poorly due to their sexual identity.

Other participants noted that avoiding stigma did not always mean they sought LGB-specific providers and venues. Both men and women in the Equality cohort associated women providers with less judgement and greater comfort. Said one 22 year-old AI/AN man from San Francisco, “I always choose a girl to go to. I don’t know why. I feel like women are more—less judgmental or they’re more comforting.” Many more women than men in the Equality cohort were comfortable accessing services from non-LGB providers than men. Though not always necessary for them, several understood how stigma could influence other people’s healthcare utilization and believed non-LGB providers and venues could be more openly supportive. As one 22 year-old Bi-/Multi-racial woman from the Tucson area put it: “Maybe [providers] should have the safe zone stickers they have here, something like that. I think it’s important to give people someone to go to who they know will accept them. I don’t think it’s important that it be a specific place, at least for me. I think having those places is really good for some people. I don’t care. I don’t need it.” Other reasons given for being comfortable with non-LGB providers and venues included being able to “pass” as heterosexual, feeling comfortable advocating for their own health needs in non-LGB venues, and feeling that sexual identity was unrelated to the services being sought.

Finally, a few participants in the Visibility cohort expressed a unique perspective related to a desire to intentionally seek care from non-LGB providers and venues. One 37 year-old

Latino man from New York said, “However, I think it’s very normal now to be LGBT affirmative and to offer services to anyone. I’m pretty sure you have to right? ... I, personally, I would prefer to go to somewhere that is just for anyone because I’m just another person. I’m not here to date you or have sex with someone here so, and that’s [not] what defines me. You know what I mean?” Unlike the women in the Equality cohort who were comfortable with either LGB or non-LGB providers, several participants in the Visibility cohort expressed an explicit preference for non-LGB providers. In this case, the participant’s sexual identity was pertinent in the context of romantic and sexual relationships and not healthcare. Other participants echoed this sentiment with statements such as “there should be no classification,” and in each case participants made reference to healthcare having been understood as an equal resource for all people.

2.2. Interconnection of expertise, identity, and service type

The perceived expertise of a provider was often attributed to the identity of the provider and the specific service being sought. Women in particular tended to associate a provider’s LGB identity with quality mental healthcare and a provider’s gender (i.e., women) with quality physical health care. For example, one 35 year-old Black woman in the Visibility cohort from the Tucson area said, “I think it’s the same, even if you’re not homophobic, it could be very difficult to adequately service a client who’s LGBT if you don’t have experience or understanding of the community, the struggles, those sorts of things, at more than a theoretical level. You’ve read a book or two, it’s not the same ... there needs to be more than just, ‘Yeah, I’m okay with seeing you because you’re gay.’” It was the therapists’ ability to relate to the life experiences of LGB people that signified quality care, regardless of whether participants were seeking care specifically for issues related to that identity. For physical healthcare it was the gender identity of providers that was of greatest concern. As one 56 year-old API woman in the Pride cohort from San Francisco stated: “Women are just—they’re just a lot more gentle when you’re getting your exams. Men, they just kind of get it done. They use a tool. Women are a little bit more gentle because they know. They know how it feels.” For these participants, the salient issue for physical health was working with someone who understood their anatomy and who they could trust to treat them gently.

This relationship to anatomy was also expressed repeatedly among men in the Pride cohort as a preference for male providers, LGB or otherwise. As one 55 year-old Black participant from the San Francisco area expressed, “It’s just that like I said, it would be nice to have someone who I can speak to about my anatomy, and that they understand what my concern may be.” Other men from each cohort endorsed similar ideas as women about providers’ expertise, identities, and service type. However, equally as consistent of a sentiment for men across cohorts was to associate the expertise of LGB-specific providers and venues with sexual health. A 38 year-old API participant in the Visibility cohort from New York compared his experiences with straight and gay physicians, saying “In my experience, when I went to someone who was not gay, they wouldn’t do an anal Pap smear. They wouldn’t do STD testing in the anus. I knew that they needed to do something, and [my current physician] does. He has more awareness around that.” These participants generally expressed appreciation for their LGB providers who discussed sexual health needs and

offered relevant services as standard practice, as compared to non-LGB physicians with whom sexual health discussions would need to be initiated.

Although expertise, identity, and service type were often interconnected, one of the most consistent patterns across all participants was the desire to prioritize expertise regardless of identity or service type. A majority of the Equality cohort endorsed this sentiment, as compared to approximately a third of the Visibility and Pride cohorts. One 36 year-old Latina woman in the Visibility cohort from New York exemplified this perspective by saying: “I don’t think you need to be what I am to empathize or to be able to do your job effectively. I don’t think a doctor needs to be gay. I don’t think it has to be gay health. I’m a woman and I don’t think my being gay impacts my biology as a woman and doctors are interested in my biology.” For these participants, basing the selection of one’s healthcare provider on demographic characteristics would not necessarily provide them with the most skilled provider, and there was no reason to think that someone would be more or less capable strictly because of their identity characteristics. As a result, their options when selecting providers were often far less restricted than those with very specific criteria.

Across all three cohorts, Latino participants made the largest number of references to providers’ expertise. Many of these reinforced the considerations of expertise, identity, and service type exemplified earlier in this section. However, one 36 year-old Latina participant in the Visibility cohort from Austin exemplified the challenges faced by many participants in identifying their ideal providers:

“Also, I was trying to find—especially for talk therapy, I was trying to find a therapist who’s a woman of color, and I did not find a single one. I’m lucky in that I found a White therapist who has really wonderful racial analysis and gets it. She understands white privilege. She understands all of it, and so it’s been really a great experience. I wanted a queer woman of color, but that was even a harder thing to find—it’s like finding a unicorn—and then taking insurance. Forget about it.”

Participants wanted the best possible providers, and the ideal provider was often linked to a variety of intersecting identities (e.g., sexual identity, gender, and race/ethnicity) they believed were related to the best care within the services types they sought. These issues were expressed by participants across age cohort, gender, and race/ethnicity, although participants in the Visibility and Pride cohorts tended emphasize multiple identity preferences more often than the Equality cohort. Participants’ preferences were frequently articulated in terms of expertise, identity, and service type, but knowing exactly the type of provider one wanted was often accompanied by a reference to the challenges associated with accessing them.

2.3. Access

Participants often discussed barriers to seeking care from their preferred providers or venues. In the Equality cohort, this was predominantly discussed in terms of being restricted by insurance provided through their parents or schools. Those who wanted to seek care from an LGB-specific provider or clinic were unable to due to the added costs of seeking care outside of the insurance networks available to them. One 22 year-old Black woman from the San Francisco area said, “Since [my University-based healthcare] is the only free service

that I currently have, then it makes sense for me to come here. If there were affordable options that were LGBT-friendly, I would definitely do that.” Although she planned to identify an LGB-specific provider or clinic when she no longer had insurance through her University, she was willing to go without it until then because her interactions with the healthcare system were so limited. Others added that, in addition to cost, the process of finding their ideal provider was too difficult. A Black man from the Austin area described the process of finding an LGB primary care physician in his area as both “daunting” and “expensive.” Financial and insurance barriers in the Equality cohort resulted in many thinking about LGB-specific providers and clinics as a concern for the future, when they had their own insurance.

Participants in the Visibility cohort also had challenges related to finding their ideal providers, but were faced with navigating their own insurance networks. For this reason, issues of access in the Visibility cohort reflect the process of navigating stigma described previously by many women in the Visibility cohort, as well as the complex considerations for expertise, identity, and service type. Sometimes this meant compromising and prioritizing their preferences, as exemplified by one 39 year-old White woman from the Austin area:

“Healthcare’s harder to navigate in many ways. I feel like I end up making choices around what’s good for my lymphedema. Then secondary is, “Are they queer friendly?” My GP, not particularly queer friendly. In fact, on my—I can tell that she’s a little horrified that I’m poly on my diagnosis form for my last annual. One of the things she put was high-risk bisexual activity as one of my diagnoses. I don’t know how you get treated for that, [laughs] but I was pretty horrified, because I’d been with one man my whole life, right?..I was pretty offended. She’s amazing for my lymphedema. I keep going back. I end up having this medical care that’s really good for the thing that it’s most medically important, but not for the stuff that’s socially important.”

Access issues were most frequently discussed in the Pride cohort, and especially among White participants. Concerns in the Pride cohort were largely consistent with those of the Visibility cohort, but several participants from the Tucson area made clear that they had never been able to identify LGB-specific providers after actively seeking them out. “If it was available I’d go. If it was specific. If it’s not particularly available here in Tucson you just make do with what ya got,” said one 57 year-old White man. This issue was not unique to Tucson, as one Latino man from Staten Island, New York expressed similar challenges. Lastly, several other participants in the Pride cohort made clear that they prioritized location and convenience over all other factors. As one 58 year-old API woman from the San Francisco area put it, “If I can do it one block down the street, I would go to the block down the street, I would rather, it doesn’t matter.” Other participants in Austin and New York City held similar sentiments.

3. Discussion

Applying BMHSU to the study of LGB people’s healthcare preferences requires that one take into account the unique ways in which their experiences as sexual minorities intersect

with healthcare. Doing so qualitatively allows researchers to draw rich data from participants that demonstrates the complexity of the decisions they face when seeking healthcare. The themes identified in this study largely reflected enabling factors of the social environment and healthcare system. Whether discussing stigma, the identification of specific providers and venues, or insurance-based restrictions, enabling factors provided the context within which one's preferences could take shape. On occasion preferences were overridden by need-based factors like the care of chronic conditions, but patterns in participants' healthcare preferences were generally most evident within the identity-based predisposing factors of gender and age cohort.

Some of the patterns identified extended across cohorts. Stigma predominantly shaped how men in all three cohorts defined their preferences, most often in terms of comfort communicating openly with providers about their sexual identities and personal lives. Men also viewed LGB-specific providers and venues as having particular expertise in sexual healthcare, and appreciated the approach taken by those providers and venues. Increasing access to LGB-specific providers and venues would address two significant enabling factors limiting the sexual healthcare of gay and bisexual men. Gay and bisexual men unable to access LGB-specific providers and venues may be left feeling uncomfortable and minimizing communication around a number of health needs. Similar findings have been reported by Mimiaga et al. (2007), who found that only half of gay and bisexual men discuss sexual health with their primary care providers. Some of those stated that they would be fine discussing sexual health if their providers brought the subject up with them, while others' explanations for discomfort around the subject included the potential for stigma and the provider's characteristics (e.g., heterosexuality, gender).

This approach may be less impactful for lesbian and bisexual women, who described much more clearly defined strategies and criteria for optimizing their healthcare beyond those pertaining specifically to their sexual identities. Although prior research describes negative encounters for lesbian and bisexual women within the health care environment (Baptiste-Roberts et al., 2016), Saulnier's (1999) research with lesbians demonstrates that, in terms of provider preferences, LGB acceptance and affirmation are not necessarily the highest priority. Participants of Saulnier's study ranked the provider's expertise above all other concerns, including their sexual identity. Policy implications of these findings include expanding efforts to increase provider competency around LGB health issues (Cahill and Makadon, 2014; Lim et al., 2014), as well as to promote increased recruitment and retention of under-represented groups within the health professions (Salsberg and Forte, 2002). Such efforts would be responsive to the predisposing and enabling factors of patient and physician identity, respectively, allowing LGB people to locate providers who represent highly specified preferences and potentially increasing the likelihood of healthcare utilization.

Another pattern that emerged pertained to some participants' inability to identify LGB-specific providers and venues. Such challenges were most frequently referenced by participants in Tucson, though a similar challenge was reported by a participant in New York. As referenced in the introduction, LGB community health centers are not evenly distributed across the United States (Martos et al., 2017). Our findings suggest that LGB people struggle to identify LGB-specific care even in places like New York City where a

larger concentration of LGB community health centers has been identified. The study by Martos and colleagues identified LGB community health centers in all four cities included in the study presented here. The question of what the healthcare preferences of LGB people are in areas with no access to LGB-specific community health centers, particularly in rural areas where access to any LGB-specific resources might be minimized (Drumheller and McQuay, 2010), remains unanswered.

At times specific provider and venue preferences were superseded by the care of chronic conditions, a need-based factor. Additional research is needed to explore which types of health issues LGB people would prefer to receive care for from an LGB provider. Similarly, given that the Equality cohort was the least likely of the three to express a preference for LGB-specific providers and venues, future research should continue to monitor how they navigate the healthcare system over the course of their lives. Comparisons could then be made to younger cohorts of LGB emerging adults to determine whether findings can be attributed to age or a unique cohort experience. Findings would provide guidance to LGB community health centers regarding future expanding efforts, for example into rural communities or by specializing in particular service type areas (e.g., sexual health services).

By contrast, the Visibility cohort expressed a unique healthcare preference that did not emerge elsewhere when participants placed an emphasis on avoiding LGB-specific providers and venues on the basis of stigma. For some, separate sources of healthcare was viewed as a form of marginalization, as healthcare was understood to be a service that all people should have equal access to, and the presence of LGB-specific providers and venues was not perceived as an enabling resources at all. This may be a remnant of this generation's experiences of hard-fought battles with medical and political institutions surrounding access to adequate treatment and care during the height of the AIDS epidemic (Forstein, 2013). Gay men in the Pride cohort, meanwhile, were most likely to specify other gay men as their preferred providers over other characteristics. This may be reflective of the era in which this cohort came into adulthood, when discrimination and harassment on the basis of sexual identity was fiercely rejected, and LGB identities were re-framed as a source of pride and strength (D'Emilio, 2012; D'Emilio and Freedman, 2012). Men and women of the Pride cohort were also much more likely than the other cohorts to express a preference for providers of the same gender due to their physical healthcare needs in older adulthood. In general, the findings suggest that provider and venue preferences in the Visibility and Pride cohorts depend on the type of healthcare services they seek, but that the potential for stigma and the demographic characteristics of providers are both key considerations when identifying a preferred provider.

3.1. Limitations

The conclusions we draw from the present study are limited: First, the interview protocol did not instruct interviewers to ask specifically about healthcare preferences. Therefore, we present findings on preferences only insofar as they relate to the importance of LGB-specific providers and venues, as well as probes questioning participants on their selection of particular providers. As a result, the data may under-represent other preferences unrelated to sexuality, including demographic factors such as age, gender, and race/ethnicity, as well as

location and venue type (e.g., health center, private practice). Yet even with these concerns in mind, the sample size and diversity across age cohort, gender, race/ethnicity, and geographic location allow for the present study to be one of the most robust accounts of LGB healthcare preferences ever conducted in the United States.

Second, the method of analysis employed in the present study limits the types and amount of inferences that can be made. Using a directed content analysis, the authors focused specifically on the portions of each interview transcript pertaining to experiences with healthcare utilization. This served as the most effective approach to analysis across such a large sample size and within such detailed Life Story Interviews. However, this comes at the expense of broader within-participant linkages and analyses that could have illuminated person-specific and lifecourse factors related to the preferences described by participants. More in-depth analyses are yet to be conducted on smaller populations within the study sample. For example, more robust comparisons could be made within and across different racial/ethnic groups, of which there were too many distinct categories for clear patterns to be identified using the directed content analysis approach when also breaking down the sample by age cohort or gender. This approach also limits the authors' ability to explore the unique ways that those in smaller groups within the sample navigate healthcare preferences in light of their particular life contexts. These include but are not limited to those in polyamorous relationships, those with HIV, or LGB parents.

4. Conclusions

The roles of LGB-specific providers and venues in the health of LGB populations have been under-studied in healthcare research despite the long history of LGB specialized healthcare services in the United States (Martos et al., 2017). A recent analysis of Behavioral Risk Factor Surveillance System (BRFSS) data found that LGB people with individually purchased insurance report lower levels of satisfaction with their healthcare than their heterosexual counterparts (Blosnich, 2017). The BRFSS data, however, does not distinguish between LGB-specific and other types of healthcare, and therefore cannot explore how levels of satisfaction may compare across provider and venue type for LGB people. The findings presented here begin to highlight the many other issues that require further investigation going forward. Needed are in-depth qualitative explorations of healthcare preferences among LGB sub-groups, as well as those that examine how healthcare preferences, and the factors influencing them, influence utilization. A large scale, nationally-representative survey on LGB healthcare preferences could test different pathways across age cohort, gender, and race/ethnicity.

Our findings show that healthcare preferences among LGB people are complex and closely linked to social changes throughout United States over time. As the social acceptance of LGB people continues to improve, the visibility of LGB people and their unique healthcare needs will increase. These will have direct policy and practical implications within health services and care. The diversity of demographic preferences expressed by participants, and the challenges in finding their ideal providers, speaks to a larger issue of diversity representation and competence within the field of medicine generally in the United States, and in LGBT specialized care specifically (Castillo-Page, 2017; Salsberg and Forte, 2002).

Renewed efforts to recruit women, racial/ethnic minorities, LGB people, and other under-represented groups across all healthcare specialization will enable LGB people to feel more confident in the quality of their care, reduce expectations of stigma and discrimination, and ultimately better serve the increasingly diversifying United States population as a whole.

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Table 1

Qualitative study sample by age cohort, gender, and race/ethnicity.

	Black	White	Latino	API	AI/AN	Bi/Multi-Race	Total
Equality Cohort							
Male	7	7	8	6	3	5	36
Female	8	7	8	6	4	7	40
Visibility Cohort							
Male	4	8	8	6	5	2	33
Female	8	8	7	5	2	6	36
Pride Cohort							
Male	5	9	7	1	1	2	25
Female	6	8	3	2	0	2	21
Total	38	47	41	26	15	24	191

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Table 2

Sample quotes of healthcare preferences among lesbian, gay, and bisexual people in the United States.

Theme	Pattern	Most Endorsed By	Sample Quote	Unique or Counter Narrative(s)
Stigma	Communication with providers	Men	<p>“As I had just mentioned, I’m still not super comfortable talking to a [heterosexual] doctor about my sexuality. At least a medical doctor ... I have a very positive, nice doctor now, but he’s a little older, and the age difference really makes it difficult for me to talk about sexuality.” (23 year-old White male, Tuscon)</p> <p>“You know how sometimes, you can initially talk to people and get an initial comfortable response level, and then more than that, either because they don’t wanna talk about it because they’re uncomfortable, or maybe they’re busy, or something. Maybe they don’t wanna seem to talk about it. That is a sort of—when it comes to gay men having intercourse, that is kind of a touchy subject.” (58 year-old White male, New York)</p>	<p>Just frustration with the queer community and just—I just wish there were—I don’t want to say—I wish I had a doctor who was of color but it just—it was a trigger for me just going [to a White gay doctor].” (23 year-old Latino male, San Francisco)</p> <p>“When I got older, [LGB-specific providers] didn’t matter as much. When I was young, it really did. I wanted that. I didn’t feel comfortable otherwise.” (55 year-old Latino male, San Francisco)</p>
Aversion of stigma does not necessarily lead to LGB-specific		Equality cohort	<p>“No, I think you need to find someone who understands it though and empathizes with it. I don’t think it hurts to go to an LGBT one, but I don’t think it’s necessary.” (23 year-old API female, New York)</p>	<p>“Well, I mean it’s important in the sense of I would like to not have a doctor saying anything annoying, but for me not—it’s not much of a concern now, cause I’m not really engaging in anything. I mean just getting a physical or anything like that, it won’t be influenced by that. When I start having to go to a gynecologist or anything like that, it would be pretty helpful to have [access to an LGBT clinic].” (24 year-old Black female, New York)</p>
Innovative strategies for provider selection		Visibility cohort women	<p>“I went to a doctor that I knew was gay just from finding her name in speeches and stuff for LGBT. That was—well, not that I knew she was gay, that I knew she was okay with the gay community. That was our fertility doctor. Then through our fertility doctor, I went and I met someone that was gay that was an endocrinologist, and then I got her to refer me to a gynecologist.” (36 year-old Latina female, Austin)</p>	
Expertise, Identity, and Service Type	LGB-specific preference for mental health	Women	<p>“The mainstream psychiatric community is founded on a sexist, racist, homophobic basis. If you’re dealing with a practice, wherein, homosexuality was seen as a mental disturbance, and people are not aware of that history, and people just, again, projecting their own shit onto you ... With an LGBT person who’s aware of the specific mental health problems that come with being LGBT in the society, then, yes, I find that would be helpful. I think more specific to my situation would be helpful.” (36 year-old Black female, New York)</p>	<p>“I think almost all my therapists have been straight. I’ve done it intentionally, because to get positive regard from another LGBTQ person? Eh. To get unconditional positive regard from a straight person when I haven’t had that any place—and back in the day, when I hadn’t had that from anybody else? Super important. I find it exceedingly healing to have a good, straight therapist.” (55 year-old White female, Austin)</p>
Gender preference for physical health		Women, Equality and Pride cohort men	<p>“It’s always a little easier to click with female doctors versus male doctors cuz you never know if a male doctor has some secret kink of messing around with gay guys when he has a wife at home.” (20 year-old Latino male, New York)</p>	<p>“That generation difference felt really weird to me. I don’t know. She was very understanding of a lot of things, but the generational difference—she was very professional. I want to talk to someone who’s closer to my age and someone—I don’t know—who is more laid</p>

Theme	Pattern	Most Endorsed By	Sample Quote	Unique or Counter Narrative(s)
LGB-specific preference for sexual health	Men	Men	<p>“Simply because I do want to become sexually active again. With that comes certain risks, certain health risks that may or may not be adequately addressed by a regular physician. I’m not saying my doctor wouldn’t still take care of me well. I don’t know that either way. I also don’t know that going to LGBT provider wouldn’t be better.” (56 year-old Latino male, Tuscon)</p>	<p>back, I’d say, which is what I found here. It’s been helpful.” (22 year-old AI male, San Francisco)</p>
Barriers to ideal providers	All	All	<p>“Well, I went to Blant and Peal and said I was looking for a therapist, and that I wanted a gay, male therapist. I think I had to wait. I think that maybe they didn’t have anybody for me right away, and then some months later, they’d contacted me, or I followed up, and Adam became available.” (58 year-old White male, New York)</p>	<p>“I went to a gay—a physician referral line and I asked for a gay doctor. I wanted a gay doctor ... Saw him for ten years. He died of AIDS. That was odd that in my personal life, everybody died of AIDS, and even in my services life, they died of AIDS. My therapist and my doctor, after I’d seen them for year and years. It was weird.” (55 year-old Latino male, San Francisco)</p>
Interest in expertise, regardless of identity or service type	All	All	<p>“I don’t believe that kinda stuff. If you’re professional, you’re educated, you’re knowledgeable, you’re compassionate. I think you can be of a different—you can be straight or whatever.” (56 year-old White male, Austin)</p>	
Restricted insurance networks, undefined preferences	Equality cohort	Equality cohort	<p>“I feel like there are people who are decent to LGBT people who aren’t specific to LGBT people. Also, I think you want the best doctor but not necessarily the best friend I guess.” (22 year-old White female, Tuscon)</p>	
Restricted insurance networks, highly specified preferences	Visibility and Pride cohorts	Visibility and Pride cohorts	<p>“I probably should look into a queer-friendly therapist, but I was just going for whatever my insurance covered, and seeing what happened from there.” (24 year-old Black female, New York)</p>	<p>“I’m concerned about a smart doctor, someone who is very insightful and sharp. I don’t care who they decide to go out behind closed doors. I guess I’m looking for quality, not any particular traits.” (34 year-old AI male, New York)</p>
Limited availability of LGB-specific	Pride cohort	Pride cohort	<p>“For medical, I would love to have a gay doctor. I have not found one in Austin. Yeah, ideally, I would prefer that.” (59 year-old White male, Austin)</p>	