Women's Health Issues xxx-xx (2017) 1–8

ELSEVIER

WOMEN'S HEALTH ISSUES

www.whijournal.com

Original article

Sexual Minority Women's Satisfaction with Health Care Providers and State-level Structural Support: Investigating the Impact of Lesbian, Gay, Bisexual, and Transgender Nondiscrimination Legislation

Aleta M. Baldwin, PhD, MPH [a,*], Brian Dodge, PhD [b], Vanessa Schick, PhD [c], Stephanie A. Sanders, PhD [d], J. Dennis Fortenberry, MD, MS [e]

[a] *Department of Kinesiology, California State University, Stanislaus, One University Circle, Turlock, California*
[b] *Department of Applied Health Science, Center for Sexual Health Promotion, Indiana University, Bloomington, Indiana*
[c] *Department of Management, Policy & Community Health, School of Public Health, University of Texas Health Science Center at Houston, Houston, Texas*
[d] *The Kinsey Institute for Research in Sex, Gender & Reproduction, Indiana University, Bloomington, Indiana*
[e] *Division of Adolescent Medicine, Indiana University School of Medicine, Indianapolis, Indiana*

Article history: Received 19 May 2016; Received in revised form 8 January 2017; Accepted 12 January 2017

A B S T R A C T

Purpose: Structural discrimination is associated with negative health outcomes among sexual minority populations. Recent changes to state-level and national legislation provide both the opportunity and the need to further explore the impact of legislation on the health indicators of sexual minorities. Using an ecosocial theory lens, the present research addresses the relationship between structural support or discrimination and satisfaction with one's health care provider among sexual minority women.
Methods: Data were drawn from an online survey of sexual minority women's health care experiences. Using the Andersen Behavioral Model of Health Services Utilization to operationalize the variables in our model, we examined the relationship between state-level nondiscrimination legislation and satisfaction with provider—a widely used measure of health care quality—through regression analysis.
Findings: Participants in structurally supportive states (i.e., those with nondiscrimination legislation) were more likely to disclose their sexual identity to their providers and to report higher satisfaction with their providers. The absence of nondiscrimination legislation was associated negatively with satisfaction with providers.
Conclusions: Results of our study show that the external environment in which sexual minority women seek health care, characterized by structural support or lack thereof, is related to perceived quality of health care.

After tremendous growth in the field of lesbian, gay, bisexual, and transgender (LGBT) health and international recognition of the urgency of attending to LGBT population health, in 2015 the American College of Physicians called for an increased research focus on LGBT health disparities, paying specific attention to state and federal laws that contribute to the continued marginalization and stigmatization of sexual and gender minority (SGM) populations (Barker, 2008; Daniel & Butkus, 2015; Institute of Medicine, 2011; Mayer et al., 2008). Despite significant changes to the social landscape over the past few decades, and the recent overhaul of the U.S. health care system, studies consistently find inequality in access to and use of health care among SGM populations (Bogart, Revenson, Whitfield, & France, 2014; Conron, Mimiaga, & Landers, 2010; Hutchinson, Thompson, & Cederbaum, 2006). Lack of access and low use of care are contributing factors to these health disparities, particularly among sexual minority women (SMW; Austin & Irwin, 2010; Bonvicini & Perlin, 2003).

Underuse of health care is well-documented among SMW. For example, lesbians are more likely to delay care and less likely to

Funding: This work was supported by The Indiana University School of Public Health- Bloomington.
* Correspondence to: Aleta M. Baldwin, PhD, MPH, Department of Kinesiology, California State University, Stanislaus, One University Circle, Turlock, CA, 95382. Phone: 209-667-3804; fax: 209-667-3763.
E-mail address: abaldwin1@csustan.edu (A.M. Baldwin).

1049-3867/$ - see front matter © 2017 Jacobs Institute of Women's Health. Published by Elsevier Inc.
http://dx.doi.org/10.1016/j.whi.2017.01.004

seek preventative care compared with heterosexual women (Buchmueller & Carpenter, 2010; Heck, Sell, & Gorin, 2006; Koh, 2000; Matthews, Brandenburg, Johnson, & Hughes, 2004). Research on health care use between groups of SMW (e.g., lesbian, bisexual, pansexual, and queer women), finds lower use among bisexual women compared with heterosexual women and, importantly, significant differences between lesbian and bisexual women (Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; Koh, 2000; Power, McNair, & Carr, 2009).

Use is related to factors at multiple ecological levels. At the interpersonal level, researchers interested in gender differences determined that women are more likely than men to discontinue care from a provider owing to dissatisfaction (Scholle et al., 2000). Although most studies on women's satisfaction with care do not examine potential differences related to sexuality, extant research has found that SMW report less satisfaction with their health care providers (HCPs) than heterosexual women (McNair, Szalacha, & Hughes, 2011; Mosack, Brouwer, & Petroll, 2013; Tjepkma, 2008). Among lesbian and bisexual women, satisfaction with care is associated with future health care practices, including delaying care (Johnson & Nemeth, 2014).

In addition to unsatisfactory interactions with HCPs, use is also influenced by bias and discrimination from within the health care system (Diamant, Schuster, & Lever, 2000; Everett, 2013; Hutchinson et al., 2006; Johnson, Mimiaga, & Bradford, 2008; Marrazzo, Coffey, & Bingham, 2005; Stevens, 1992). It can be argued that discrimination against SGM individuals is endemic to the U.S. health care system, given the history (and present) of the medicalization of "homosexuality" and "transsexualism." Further, barriers to care are built into the health care system through the circumstances under which care is available, because most American adults are insured through their or their spouse's employer (Chance, 2013). Until the recent Supreme Court decision in *Obergefell v. Hodges* (2015) effectively legalized same-sex marriage in all 50 states, many states in the United States did not allow same-sex couples to be married, prohibiting health insurance benefits to be extended to same-sex/gender partners, and contributing to high rates of uninsured and underinsured SGM individuals (Barker, 2008; Bonvicini & Perlin, 2003).

There is a dearth of information on the role of environmental factors related to SGM health and health care use (Phillips, Morrison, Andersen, & Aday, 1998). However, just as interpersonal and system-level discrimination play a role in contributing to health disparities, so too do environmental factors, such as state legislation. Research investigating the role of structural discrimination on the health of sexual minorities using nationally representative, population-based data significant relationships between state-level policies institutionalizing discrimination against SGM individuals and negative health outcomes (Hatzenbuehler, Keyes, & Hasin, 2009; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). Through assessing a variety of outcome variables and controlling for relevant covariates, these studies demonstrate that state protection of rights reduces health inequities (Hatzenbuehler et al., 2009, 2010; Krieger, 2014).

Between 2011 and the Supreme Court decision in 2015, many states began to legally recognize same-sex marriage and pass nondiscrimination legislation protecting individuals from discrimination on the basis of sexual orientation and gender identity. These recent changes create both an opportunity and a need to explore additional relationships between structural support and health indicators. Of particular interest to this study is patient satisfaction with provider, a widely used metric for monitoring and evaluating health care quality and assessing the relationship between physician and patient (Cleary & McNeil, 1988; Fenton, Jerant, Bertakis, & Franks, 2012; Li, Matthews, Aranda, Patel, & Patel, 2015; Sitzia & Wood, 1997; Scholle, Weisman, Anderson, & Carmacho, 2004).

Aims

This research extends the available literature on SMW's health disparities. Specifically, through measures of state-level legislation and patient satisfaction, this study examines the relationship between structural support and health care quality among a sample of SMW.

Conceptual Framework and Research Hypotheses

Two theoretical frameworks guide this research. The first, ecosocial theory, concerns the multiple pathways through which discrimination drives social inequalities in health, of which state-sanctioned discrimination is a particular concern (Krieger, 2012). Primarily used to examine epidemiologic inequalities, ecosocial theory posits that social arrangements of power shape the epidemiologic profiles of a given society (Krieger, 2012). Further, ecosocial theory calls attention to variation within social groups (e.g., differences between lesbian and bisexual women) and in doing so, "promotes nuanced, population-level thinking about how multiple dimensions of social inequality singly and jointly influence the patterning of health in historical and ecological context" (Agenor, Krieger, Austin, Haneuse, & Gottlieb, 2014, p. 111).

The second conceptual framework is the Andersen Behavioral Model of Health Services Utilization, which guides our assessment of the relationship between structural support and health care quality (Andersen, 1995). The Andersen model proposes that 1) need, 2) predisposing factors, 3) enabling resources, and the 4) external environment in which people seek care work together to determine 5) health care services use. Given its ecological focus, this models fits well with the ecosocial framework. Although the Andersen model is often used to assess the strength of predictors of health care use (Babitsch, Gohl, & von Lengerke, 2012), it is particularly useful for our purposes because it accounts for the recursiveness of health care use and the feedback loop between 6) outcomes—particularly patient satisfaction—and use.

We hypothesize that individuals living in states that offer no structural support (i.e., those without nondiscrimination legislation) will report less satisfaction with their HCP than those participants in states with structurally supportive legislation. Guided by ecosocial theory, we also explored differences between groups of SMW related to satisfaction with care.

Methods

This paper presents primary analyses of data drawn from an online survey of LGBTQ-identified individuals residing in the United States. Recruitment messages for the study were distributed online through email, LISTSERVS, and social networking websites such as Twitter and Facebook. Recruitment messages included a brief description of the study and were shared widely on social media. Cisgender women (individuals assigned female sex at birth and living as women) who identified as lesbian/gay, bisexual or queer, as well