

# GENDER IDENTITY DIFFERENCES IN HEALTH CARE ACCESS AND SATISFACTION

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## INTRODUCTION

Gender minority (i.e. transgender, gender diverse) individuals experience stark health disparities when compared to cisgender persons, including elevated risk for cardiovascular disease,<sup>1</sup> substance use disorders,<sup>2</sup> chronic diseases like asthma and obesity,<sup>3,4</sup> and HIV.<sup>5</sup> Despite well-documented need, gender minority people continue to experience unique barriers to adequate and equitable health care. For example, gender minority individuals report financial barriers to seeking care due to lack of insurance, insurer refusal to cover trans-specific healthcare, and expensive co-pays.<sup>6,7</sup>

Even when transgender persons can afford the costs of care, they are often met with a health care workforce that is not knowledgeable about their unique health needs or is outright discriminatory.<sup>6-10</sup> These experiences often prompt gender minority people to delay care or avoid health care services altogether.<sup>6,11,12</sup>

There remain limited opportunities to assess gender identity-related disparities in health care access at the population-level, yet these data are important for informing policies that ensure the health of transgender persons.

## METHODS

Data are from cycle 17 of the Association of American Medical Colleges (AAMC) biannual Consumer Survey of Health Care Access (2019; n=2,115 [n=40 transgender]). This internet-based survey captures a U.S. national sample of respondents who reported needing health care in the last 12 months.

Due to power limitations, gender identity was coded as a binary variable reflecting cisgender and transgender (e.g., transgender male/man, transgender female/woman, genderqueer/gender non-conforming, or something different) identities. Health care access and satisfaction was measured with nine yes/no items. These same items were then used in a composite index of healthcare access barriers (Cronbach's alpha = 0.78).

Poisson regression models were used to generate prevalence ratios comparing transgender participants to cisgender participants for each healthcare outcome, and a cumulative prevalence ratio for the total number of healthcare barriers.

## KEY FINDINGS

Compared to cisgender participants:

- Transgender persons were 30% less likely to receive needed healthcare.
- Transgender persons were 35% less likely to not delay health care.
- Transgender persons were 25% less likely to be satisfied with their last health care visit.
- Transgender persons were almost twice as likely to report barriers to health care.

## POLICY IMPLICATIONS

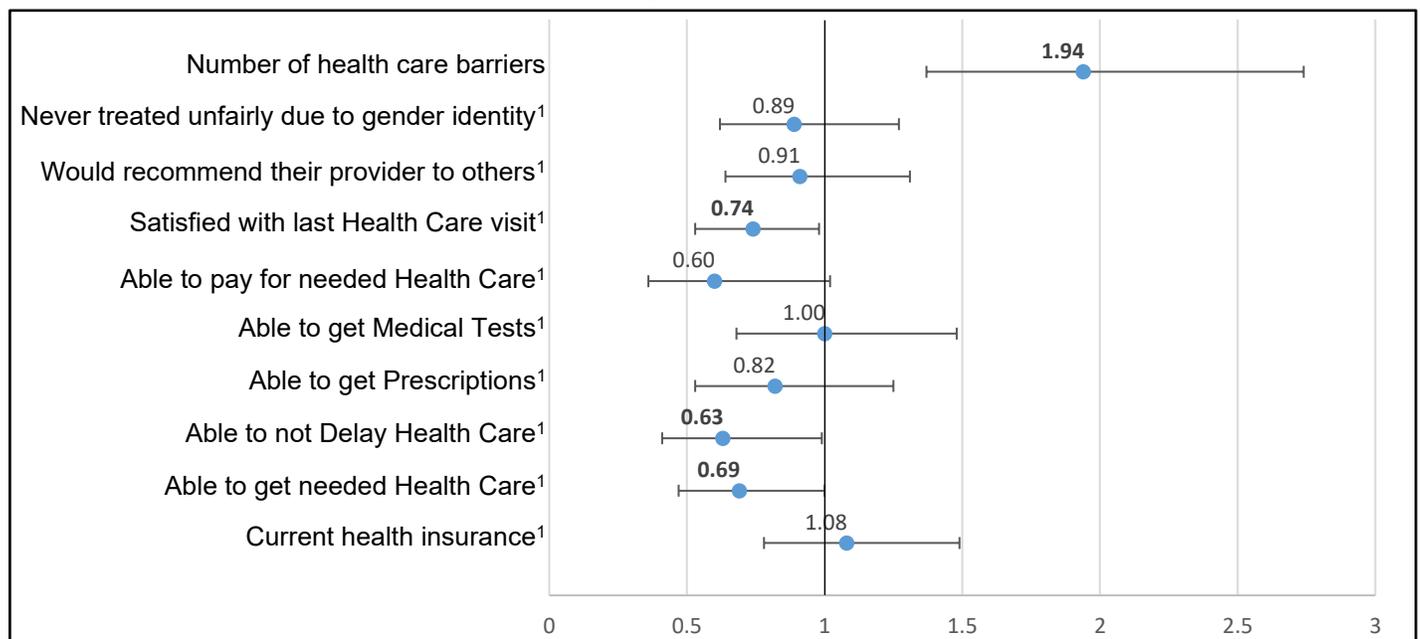
- Non-discrimination policies and coverage for trans-affirmative care would help alleviate cost-related barriers to care.
- Policies that eliminate stigma and increase provider competency when working with transgender patients are necessary for alleviating discriminatory practices in medical care.

## RESULTS

Roughly, 1.9% of the sample reported being transgender. When compared to their cisgender counterparts, transgender participants were younger, more likely to have less than a high school education, and more likely to be employed part-time or unemployed.

Poisson regression models revealed that, compared to cisgender participants, transgender respondents were less likely to receive needed health care (PR = 0.69, 95% CI 0.47, 1.00), not delay health care (PR = 0.63, 95% CI 0.41, 0.99), and be satisfied with their last healthcare visit (PR = 0.74, 95% CI 0.53, 0.98). Transgender participants were also nearly twice as likely to have a greater number of barriers to health care (PR = 1.94, 95% CI 1.37, 2.74).

Prevalence Ratios for Health Care Access and Satisfaction Indicators



Significant ( $p < .05$ ) associations bolded. <sup>1</sup>Adjusted for sex assigned at birth and age. Ratio numerator = transgender; denominator = cisgender.

## DISCUSSION

Given that health insurance coverage did not vary by gender identity, there are likely other factors that mitigate transgender people's engagement with health care services. For example, these findings might suggest that transgender participants in our sample may be underinsured (e.g. high deductible insurance plans, high cost-sharing burden), have insurance that does not cover transition-related care, or face obstacles with insurance coverage related to their gender identity.<sup>5-7</sup> Cost-related barriers may also be related to increased rates of poverty among transgender adults.<sup>12</sup>

Unfair treatment due to gender identity did not vary by gender identity but satisfaction with the most recent health care visit did. Thus, transgender respondents in our sample may be receiving poorer care overall, not just related to their unique needs as gender minorities.

Although the proportion of our sample that identified as transgender is consistent with population-based studies, our sample was slightly underpowered to detect differences between cisgender and transgender and limited our ability to assess differences in health care access across transgender binary and non-binary participants. More research is needed to better understand how barriers to care influence transgender people's health care engagement and subsequently, their health.

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