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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

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ABSTRACT

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

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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

Table 1
Constructs, Variables, and Related Measures

Construct	Variable	Survey Measure
(1) Predisposing characteristics		
	Age	What is your age in years?
	Sexual identity	What term or terms do you use to identify your sexuality privately?
	Race	Which best describes your race?
	Ethnicity	Are you of Hispanic, Latina/o, or Spanish origin?
	Residency	How would you describe the place where you live?
	Education level	What is the highest level of education you have completed?
	Chronic illness	Do you have a chronic illness?
(2) Enabling resources		
	Income	What would you say is your average household income?
	Previous disclosure	Have you told your health care provider your sexual identity?
	Disclosure + legislation	Previous disclosure + State-level legislation
	Insurance status	Do you currently have health insurance?
(3) Need		
	Health status	How would you rate your overall health?
(4) External environment		
	State-level legislation	In which state within the United States do you live? + Presence or absence of nondiscrimination laws
(5) Health service use		
	Delayed/forgone care	Have you ever felt as though you needed to see a health care provider, but delayed going or decided not to see one?
	Quality of Physician–Patient Interaction scale	14-item scale rating quality of patient–physician interactions
(6) Outcome		
	Satisfaction with health care provider	How satisfied are you with your health care provider?

as trans* individuals,[1] age 18 years and over and living in the United States, were invited to participate. Although trans* and genderqueer individuals participated in this study, the LGBT community is heterogeneous, and the health risks and outcomes that SMW and trans* individuals face vary significantly. As such, we restricted analyses for this particular study to sexual minority women participants. Of the 510 participants in the LGBTQ Healthcare Experiences Study, 352 were cisgender women who provided data on state of residence and are included in these analyses.

Individuals who met the eligibility criteria and consented to participate were directed to the survey instrument. On average, the survey took approximately 25 minutes to complete ($M = 26.53$, $SD = 16.33$). Upon completion, participants were directed to a separate online database where they could provide an email address if they wished to enter a drawing for a 1 in 15 chance of winning a $25.00 online gift card. All study protocols were reviewed and approved by the Institutional Review Board of Indiana University — Bloomington.

Measures

Variables were operationalized in terms of the Andersen model. Table 1 presents the variables included and their related survey measures. Our outcome variable was measured through self-reported satisfaction with HCP on a 5-point Likert scale item. We defined HCP for participants as “the medical professional you seek out most often when you need a check-up, etc.” We operationalized the external environment in which participants seek health care by examining the state legislation that existed during the month prior to data collection (January, 2015) and created a variable to denote whether or not a participant lived in a structurally supportive state (i.e., with LGBT nondiscrimination legislation; Table 2).

Predisposing characteristics were operationalized through sociodemographic characteristics including residency, age, sexual identity, race/ethnicity, highest level of education, and presence of a chronic illness. Enabling resources were operationalized through income level and having previously disclosed sexual identity to her HCP. A systematic review of the use of the Andersen model found that disclosure of sexual identity has not yet been used as a variable nor aided in the operationalization of any construct within the Andersen model (Babitsch et al., 2012). However, research indicates that for SMW, identity disclosure is related to increased use and satisfaction with care (Barbara, Quandt, & Anderson, 2001; Bergeron & Senn, 2003; Steele, Tinmouth, & Lu, 2006). As such, we included identity disclosure in our model as an enabling factor and created an additional variable to denote whether a patient disclosed their identity in a state with or without nondiscrimination legislation. Need for care was measured through participants' self-reported overall health status on a 5-point Likert scale item.

Finally, we assessed health services use through participants' reports of having previously delayed or forgone care, as well as mean scores on the Questionnaire on the Quality of Physician-Patient Interaction (QQPPI) (Bieber, Mueller, Nicolai, Hartmann, & Eich, 2010). The QQPPI is a validated, unidimensional scale of 14 items, and is highly rated among similar measures ($\alpha = 0.95$). The QQPPI is a relatively new tool and has only been used in one other sample of SMW (St. Pierre, 2013). In our sample, the QQPPI was highly reliable ($\alpha = 0.96$), with a mean score of 2.85 ($SD = 0.753$).

Analyses

Using descriptive statistics and bivariate analyses, we tested for differences in sociodemographic characteristics between sexual identity groups (e.g., lesbian, bisexual, pansexual, queer) and then assessed whether participant's health-related characteristics significantly differed with the presence of state-level nondiscrimination legislation. To determine if within-state variation needed to be accounted for in our model, we

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[1] Trans* denotes individuals who identify on the transgender spectrum, including those who identify as genderqueer or gender neutral.

Table 2
States with Lesbian, Gay, Bisexual, and Transgender Employment and Housing Nondiscrimination Laws

Existing Before January, 2015	Passed/Implemented after January, 2015
California	Utah
Colorado	New York
Connecticut	
Delaware	
Hawaii	
Iowa	
Illinois	
Maine	
Maryland	
Massachusetts	
Minnesota	
New Jersey	
New Mexico	
Nevada	
Oregon	
Rhode Island	
Vermont	
Washington	
Washington, DC	
Puerto Rico	

Source: Movement Advancement Project. (2016). [Interactive map of non-discrimination laws] Equality maps: Non-discrimination Laws. Available: www.lgbtmap.org/equality-maps/non_discrimination_laws

conducted a likelihood ratio test for model differences. The Akaike Information Criterion (AIC) of the model with a unique intercept for each state (AIC = 937.2) did not differ significantly from a model that included a fixed intercept for each state (AIC = 937.7). The nonsignificant difference between the two models indicated no need to include random effects for state, $\chi^2(1) = 1.43$; $p = .231$.

After establishing that the data did not violate the assumption of multicollinearity (variance inflation factors were between 1.01 and 1.14), we conducted a linear regression on the measure of satisfaction. Initially, we anticipated including insurance status (i.e., if and how participants were insured) in the regression model as an enabling characteristic. However, there was too little variability among participants in terms of insurance status and perfect separation occurred. As such, insurance status was removed. We conducted the likelihood ratio test in R, and all other analyses in SPSS (Version 22; SPSS, Inc., Chicago, IL).

Results

Sociodemographic and Health-Related Characteristics

A total of 352 SMW were included in these analyses. The mean age of the sample was 32 years ($SD = 9.18$). As shown in Table 3, our sample was relatively young, with 85.2% of women under the age of 40 ($n = 300$). Participants who identified as bisexual (29.8%, $n = 105$), queer (29.8%, $n = 105$), or lesbian (27.3%, $n = 96$) were nearly evenly distributed within the sample; 13.1% ($n = 46$) participants identified as pansexual. The majority of respondents were White (87.4%, $n = 306$) and the sample was highly educated: 33.3% had a master's degree ($n = 117$) and an additional 33.9% had a bachelor's degree ($n = 119$).

Tests of difference (χ^2, ANOVA) were conducted to discern significant differences between identity groups related to demographic and health-related characteristics, which might result in differences related to our outcome variable (data not shown). In terms of demographic characteristics, queer women were significantly more likely to live in urban areas ($\chi^2(2) = 11.814$; $p = .003$). More bisexual ($\chi^2(1) = 8.765$; $p = .003$), but fewer lesbian women ($\chi^2(1) = 7.106$; $p = .008$) were of Hispanic origin. Significantly more bisexual participants had a bachelor's but not a master's degree ($\chi^2(3) = 9.300$; $p = .026$). Queer ($M = 29.664$, $SD = 5.31$, $p < .001$), pansexual ($M = 29.00$, $SD = 5.69$; $p < .001$), and bisexual ($M = 31.46$, $SD = 9.26$; $p < .001$) participants were significantly younger than lesbian participants ($M = 37.08$, $SD = 11.59$; $p < .001$). Finally, there were no differences between identity groups in terms of chronic illness that might impact use of care (e.g., diabetes, asthma, depression).

Table 3
Demographic Characteristics ($n = 352$)

Characteristics	n	%
Age (yrs)		
18–24	62	17.6
25–29	98	27.8
30–39	140	39.8
40–49	26	7.4
≥50	26	7.4
Sexual identity		
Bisexual	105	29.8
Queer	105	29.8
Lesbian	96	27.3
Pansexual	46	13.1
Race		
White	306	87.4
Black	18	5.2
Asian	16	4.6
Multiracial/other	10	2.9
Ethnicity		
Non-Hispanic	320	91.4
Hispanic/Latina	30	8.5
Education		
Less than a BA	70	19.9
Bachelor's	119	33.9
Master's	117	33.3
PhD, MD, JD	45	12.8
Income (US$)		
<25,000	77	22.5
25,000–39,000	55	16.1
40,000–54,000	49	14.3
55,000–84,000	72	21.1
≥85,000	89	26
Residency		
Rural	34	9.8
Suburban	123	35.3
Urban	191	54.9

Given the income and educational level of the sample, it is not surprising that more than 95% of respondents were insured at the time of the survey ($n = 339$), and that 93.5% ($n = 330$) reported having a primary HCP. There were no differences in insurance status or having a primary care provider between residents of states with nondiscrimination legislation and those living in states without such legislation. Most participants had seen their primary care provider within the last year ($n = 266$, 73.5%), and nearly one-half considered their health "good" or "very good" ($n = 263$, 46.8%). A little more than one-third (34.6%; $n = 121$) indicated living with a chronic illness. As shown in Table 4, there were no differences in health-related characteristics by state legislative policy aside from the most recent Pap test.

Structural Support and Satisfaction with HCP Provider

Bivariate analyses showed no difference in delaying or foregoing care by state legislation, but participants in states with nondiscrimination legislation were significantly more likely to

Table 4
Health-Related Characteristics by State Lesbian, Gay, Bisexual, and Transgender Nondiscrimination Legislation ($n = 352$)

Characteristics	Overall		Legislation			
			No Legislation		SOGI Protected	
	n	%	*n*	%	*n*	%
Insurance status						
Insured through employment	190	54.4	95	54.9	95	54.0
Insured as a dependent	78	22.3	34	19.7	44	25.0
Private insurance	35	10.0	15	8.7	20	11.4
Public insurance	31	8.9	22	12.7	9	5.1
Uninsured	15	4.3	7	4.0	8	4.5
Primary HCP						
Yes	328	93.4	164	93.7	164	93.2
No	23	6.6	11	3.6	12	6.8
Most recent HCP visit						
<1 month	81	23.1	46	26.3	35	19.9
Between 1 month and 1 year	183	52.1	86	49.1	97	55.1
Between 1 and 2 years	43	12.3	20	11.4	23	13.1
Between 2 and 5 years	21	6.0	12	6.9	9	5.1
Overall health status						
Poor to fair	47	13.5	24	13.6	23	13.1
Good	150	42.9	69	39.2	81	46.3
Very good	113	31.9	59	33.5	54	30.9
Excellent	38	10.8	21	11.9	17	9.7
Chronic illness						
Yes	121	34.8	58	33.5	63	36.0
No	227	65.2	115	66.5	112	64.0
Last cervical cancer test*						
Past year	144	40.9	73	41.5	71	40.6
Past 3 years	128	36.4	64	36.4	64	36.6
>3 years	43	12.2	24	13.6	19	10.9
Never tested	36	10.2	15	8.5	21	12.0
Lifetime STI diagnosis						
≥1	152	43.9	76	44.2	76	43.7

Abbreviations: HCP, health care provider; SOGI, sexual orientation and gender identity; STI, sexually transmitted infection.
*$p < .05$.

Table 5
Satisfaction with Provider: Multiple Linear Regression Analysis ($n = 352$)

Variable	β	SE	95% CI	*p* Value
Age	−0.002	0.008	−0.018 to 0.014	.807
Income	0.017	0.022	−0.026 to 0.060	.442
QQPPI score*	0.777	0.080	0.620 to 0.933	.000
Legislation				
SOGI protected	–	–	–	–
No protections†	−0.288	−0.119	−0.522 to −0.053	.016
Urbanicity				
Urban	–	–	–	–
Rural	−0.087	0.174	−0.427 to 0.254	.618
Suburban	−0.062	0.127	−0.310 to 0.187	.627
Sexual identity				
Lesbian	–	–	–	–
Bisexual	0.093	−0.148	−0.197 to 0.383	.530
Queer	0.061	−0.123	−0.180 to 0.302	.620
Pansexual†	−0.445	−0.205	−0.848 to −0.043	.030
Race				
White	–	–	–	–
Black	0.075	0.353	−0.617 to 0.767	.832
Asian	0.267	0.217	−0.157 to 0.692	.217
Multiracial/other*	0.734	0.158	0.425 to 1.044	.000
Ethnicity				
Non-Hispanic/Latina	–	–	–	–
Hispanic/Latina	0.084	0.208	−0.323 to 0.490	.687
Outness				
Not out to HCP	–	–	–	–
Out to HCP	−0.229	0.127	−0.478 to 0.021	.073

Abbreviations: HCP, health care provider; SOGI, sexual orientation and gender identity.
*$p < .001$.
†$p < .05$.

have disclosed their sexual identity to their HCP ($\chi^2(1) = 5.350$; $p = .021$) and report significantly higher satisfaction with their HCP (t(298) = 2.566; $p = .011$.). Disclosure of sexual identity was related to higher quality interactions between patient and provider (t(276) = 3.741; $p < .001$). Positive correlations existed between QQPPI score and satisfaction with HCP ($r = .463$; $p < .001$), and overall health ($r = .147$; $p = .01$). Overall health was also positively associated with one's satisfaction with HCP ($r = .199$; $p = .001$), and not having delayed or forgone care (t(307) = 3.516; $p <$ 001.).

The relationship between nondiscrimination legislation and satisfaction with provider is presented in Table 5. A multiple linear regression was conducted to assess satisfaction with HCP based on state-level structural support, including 1) previous disclosure of sexual identity to HCP, 2) disclosing in a state without nondiscrimination legislation, 3) having previously delayed or forgone care, 4) QQPPI score, 5) overall health status, 6) sexual identity, and 7) sociodemographic characteristics. The results of the first regression analysis showed that three variables did not add to the model. Disclosing in a state without nondiscrimination legislation, overall health status, and having delayed or foregone care were nonsignificant and were removed from the model. Sociodemographics and all significant variables remained in the second model. These results indicate that nondiscrimination legislation as well as QQPPI score, sexual identity, and race were significantly associated with satisfaction with provider.

In support of our first hypothesis, state-level policies were related to patient satisfaction. Specifically, among participants living in states without structural support satisfaction with provider was significantly lower than among those participants living in states with protective legislation ($\beta = -0.288$, $p = .016$). These results indicate that living in states without explicit protection from discrimination may result in lower quality of care. All other things constant, the reported quality of patient-provider interactions (QQPPI score) was positively associated with satisfaction with HCP ($\beta = 0.777$, $p < .001$). We also found a significant relationship between more stigmatized sexual identity and satisfaction with care. Compared with lesbian identity, pansexual identity was negatively associated with satisfaction with HCP ($\beta = -0.445$, $p = .03$).

Discussion

Most studies of the impact of discrimination on health have focused on interpersonal discrimination; much less is known about how structural discrimination or structural support may influence health and health care. Previous research has found that structural discrimination negatively impacts mental health outcomes among sexual minority individuals via structural stigma (Hatzenbuehler et al., 2009, 2010). Our findings are complementary, demonstrating a relationship between structural support and perceived quality of health care for SMW.

Using Andersen's Behavioral Model of Health Services Utilization to determine appropriate covariates, in a regression model holding other significant variables constant, protective legislation was positively associated with patient satisfaction. Those participants living in states where discrimination is not legally prohibited reported significantly less satisfaction with their HCPs. We infer from these results that the external environment in which SMW receive care is related to the perceived quality of care they receive. The results of our study lend support to the hypothesis that laws and policies that reinforce marginalization, discrimination, social stigma, and rejection of SGM persons are associated with negative health outcomes (Daniel & Butkus, 2015). These findings are pertinent given the established relationships between patient satisfaction and health care use (Johnson & Nemeth, 2014; Scholle et al., 2000).

The nascent body of literature on structural stigma and health points to the need for research exploring potential mediators and moderators of structural stigma (Hatzenbuehler, 2014). We hope, too, that the present research will aid in future explorations of additional indicators of structural stigma, such as health care quality. Although all of the specific pathways are still unknown to us, social conditions such as state-sanctioned discrimination or support structure not just access to health and quality of care, but health itself (Braveman, 2010).

A major strength of this study is that it presents data on a number of SMW who are underrepresented in health research or often left out entirely because they do not self-identify as lesbian or bisexual. Ecosocial theory guides researchers to look for differences within groups, and our results indicate that pansexual women tend to report less satisfaction with care than do lesbian women. These findings lend support to the hypothesis that sexuality has an independent effect on receipt of quality care, and further indicates the need for an increased study of the relationship between sexual minority identities and use of health care (Diamant, Wold, Spritzer, & Gelberg, 2000; Fredriksen-Goldsen et al., 2010).

Although it is necessary to make comparisons between SMW and heterosexual women to determine where disparities exist, such comparisons potentially eclipse differences between SMW. It is frequently the case that women who have sex with women or who identify as anything other than heterosexual, are grouped together regardless of their identities and compared with heterosexual women, or removed from the analyses owing to a lack of statistical power (Cochran & Mays, 2012; Eliason, Radix, McElroy, Garbers & Haynes, 2016; Eliason et al., 2015; Johnson & Nemeth, 2014; Mosack et al., 2013; Rankow & Tessaro, 1998). Our study had sufficient numbers of queer and pansexual participants, giving us the statistical power needed to include these underrepresented groups in our analyses. Previous research has confirmed a difference in patient satisfaction between heterosexual women and lesbian/gay and bisexual women, with the former more likely to report being very satisfied with the care they receive from their HCP (Diamant et al., 2000). Very few studies provide an account of differences in health outcomes between SMW, although results from research comparing satisfaction with HCP within a sample of SMW are mixed (Mosack et al., 2013). With increasing numbers of SMW identifying with bisexual, pansexual, and other nonlesbian identities, these findings reinforce the need for additional research on the health of SMW who identify with labels other than lesbian and bisexual (Rupp & Taylor, 2013; Vaccaro, 2009).

Limitations

Our findings should be considered alongside the limitations of the study. Although we attempted to recruit a diverse sample of SMW, we are limited by the homogeneity of our sample. Furthermore, because the data were cross-sectional, it is not possible to determine directionality. Future research on the knowledge that participants and medical providers have of current policies is also warranted. Although our results demonstrate that structural support is related to evaluations of health care quality, future studies should examine potential mechanisms that bring about relationships between structural support or discrimination and health care quality. Finally, although we did not have a nationally representative sample to analyze, as previous research on structural stigma and health outcomes has had, we nevertheless are able to add to the growing body of research connecting structural discrimination to health.

Implications for Policy and/or Practice

According to Krieger (2014) regardless of effect, the rationale for exploring the relationships between discrimination and health is “to generate knowledge useful for guiding policies and actions to prevent and rectify harm and advance health equity” (p. 645). The results of this research highlight the need for public health practice to not only address the individual and interpersonal level factors which decrease use among SGM populations, but also the social and political environment in which individuals seek and receive care. Our results have important implications for public health professionals and policy makers. Currently, 30 states do not extend protections against discrimination to both sexual orientation and gender identity. Nondiscrimination legislation secures such rights. Increasingly, states are turning to religious freedom restoration legislation, which offers legal protection to discriminate. Given the “health in all policies,” initiative promoted within the public health field as a strategy for addressing the social determinants of health that perpetuate disparity, medical and public health communities have a vested interest in supporting the rights of SGM individuals beyond those rights that seem to be directly related to health (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013). Further, because SMW women tend to experience a higher burden of negative health outcomes (Blosnich, Farmer, Lee, Silenzo & Bowen, 2014) we should make every effort to improve use by ensuring that the quality of their care is satisfactory.

A number of professional organizations in addition to the American College of Physicians, including the American Medical Association and the Society for Adolescent Health and Medicine have position papers and resolutions regarding SGM health care and attending to health care disparities. These resources can be useful in influencing state and local governments to adopt LGBT nondiscrimination policy. For-profit health care networks, too, have an interest in supporting LGBT nondiscrimination, as laws and policies that ensure protections for LGBT individuals may reduce health care costs (Hatzenbuehler et al., 2011). This economic effect will likely grow given the greater access to care for SGM individuals under the Affordable Care Act. Existing research on state-level policies and the health of SGM populations calls for partnerships between the health community and policymakers to eliminate institutional discrimination against SGM populations (Hatzenbuehler et al., 2009). Findings from this research lend support to such measures and suggest the need for a renewed and broadened engagement with the “health in all policies" initiative, because policymaking is a social determinant of health that those in the medical and public health communities have a responsibility to address.

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