European Journal of Internal Medicine 121 (2024) 35–39

Contents lists available at ScienceDirect

European Journal of Internal Medicine

journal homepage: www.elsevier.com/locate/ejim

Clinical Insights

Interventions targeting LGBTQIA+ populations to advance health equity

Lia Ginaldi [a,b,c], Massimo De Martinis [a,c,d,e,*]

[a] Department of Life, Health and Environmental Sciences, University of L'Aquila, Italy
[b] Allergy and Clinical Immunology Unit, Center for the Diagnosis and Treatment of Osteoporosis, AUSL 04, Teramo, Italy
[c] Technical Group for the Coordination of Gender Medicine, Regione Abruzzo, Italy
[d] Long-Term Care Unit, "Maria SS. dello Splendore" Hospital, AUSL 04, Giulianova, Teramo, Italy
[e] UniCamillus-Saint Camillus International University of Health Sciences, Rome, Italy

ARTICLE INFO

Keywords:
LGBTQIA +
Gender
Sex
Sexual orientation
Healthcare
Sex and gender minorities
Disparities
Gender medicine
Health data
Epidemiology
Prevention
Screening
Intersectionality

1. Introduction

The role of the physician is not limited to the provision of clinical care, but must also extend to identifying barriers to accessing care that patients encounter. As doctors we are called and must commit to optimizing clinical care and promoting social justice. We must turn our attention and special care to the most vulnerable populations and work to dismantle all structural inequalities.

However, discrimination greatly depends on individual actions, motivations, prejudices, as well as the social and cultural norms by which we all are contaminated. There are no social or cultural categories uncontaminated from this point of view only by virtue of their professional position as in the case of the health workforce, from whom we would expect the most absolute dedication and ability to welcome and take care for the person regardless of any categorization or difference.

These professionals reflect the various faces of our societies and can also be insensitive, unconscious barriers or even actors of discrimination against minorities and specifically LGBTQIA+ populations. Despite this, by their intrinsic nature the health workforce could be a point of strength in the fight against any type of discrimination.

Healthcare workers could be a leading force to what, nevertheless, should be a starting point of a necessarily wider view aimed at reducing discrimination in every domain of life weather it is related to access to care, food, housing, education, or social life.

Social, environmental, health and personal factors are interconnected and hinder health equity and we must become main actors of actions to mitigate their effects.

Unfortunately we note that we are often still in the preliminary phase, that is, the one in which we need to explore our role in perpetuating, intentionally or not, disparities in health care.

Several professional organizations across the United States, such as the American Board of Internal Medicine (ABIM) and ABIM Foundation, have posed this issue and are working to address it, repositioning in an actively inclusive, egalitarian and anti-inequality attitude and broadening the vision as much as possible to each corner of society where poverty and inequality of care can hide.

Recently the American College of Physicians acknowledged the role of social determinants in health and examining the complexities

* Corresponding author at: Department of Life, Health and Environmental Sciences, University of L'Aquila, Piazzale Salvatore Tommasi n. 1, L'Aquila 67100, Italy.
E-mail address: demartinis@cc.univaq.it (M. De Martinis).

https://doi.org/10.1016/j.ejim.2024.01.008
Received 19 October 2023; Received in revised form 28 December 2023; Accepted 11 January 2024
Available online 18 January 2024

associated with them, offered recommendations on better integration of social determinants into the health care system while highlighting the need to address systemic issues hindering health equity [1].

In this view deserves special attention the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and the + holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities) population. On the basis of recent data [2] it appear to be growing numerically, but these are generally statistics based on self-reporting and this can mean that beyond a real numerical increase there is however, above all in young populations, a predisposition and a need to come out into the open and this will be to the benefit of the whole of society and the well-being for all.

According to the most recent estimates 5–10 % of the population is represented by LGBTQIA+ people, which, due to missing gender, sex and sexual orientation (GSSO) data in most digital health systems, is completely invisible and may instead represent a group at high risk of reduced clinical report and adverse outcomes.

In recent years, public health awareness of health disparities among the LGBTQIA+ population has increased and claim interventions [3].

The medical community can build systems that are responsive to the needs of LGBTQIA+ patients [4].

LGBTQIA+ are members of every community and often sex and gender minority (SGM) identities intersect with other core aspects of their identity that may contribute to their negative health-related experiences. The LGBTQIA+ communities include members of every race, ethnicity, religion, physical ability/disability, mental capacity, age and socio-economic group. *O*bjectives to improve health of LGBTQIA+ people was included in Healthy People 2020 recognizing the health and healthcare gap respect to the heterosexual counterpart. Healthy People 2030 renews this commitment as evidence that achieving these equity and inclusion goals is not easy and that beyond the proclamations, there is still a lot to do.

The aging population will put our healthcare systems to the test and only an immediate and adequate investment in prevention can help avoid their collapse. For a prevention plan to be successful it is necessary to be able to disseminate it to all strata of society and obtain adequate participation from the entire population. The prerequisite for this is the elimination of barriers and inequalities and the recovery of trust from all citizens, especially the most disadvantaged and discriminated.

The LGBTQIA+ populations are less likely to report engagement in programs for better health-related behaviors. Despite the proliferation in recent times of articles focusing attention on SGM populations, the results are still insufficient and not very encouraging [5]. If more has been studied in the field of psychiatric diseases, addictions, sexually transmitted diseases and more recently in the field of cardiovascular, metabolic and cancer diseases still little is investigated and we know about chronic inflammatory, autoimmune, degenerative, allergic [6], endocrine, kidney [7], central nervous system, respiratory diseases [8].

Even gerontological research has not paid sufficient attention to the LGBTQIA+ populations [9]. These are particularly fragile and vulnerable groups which, due to the weight of their age and background, could have greater health needs and be more sensitive to experiences of stigmatization, discrimination and victimization with less capacity for resilience and reaction with respect to the new generations. Several actions may help to overcome disparities (Fig. 1).

Evidence of disparities is mainly derived from the US, a nation whose healthcare system is often criticized for its inequity towards minorities

Fig. 1. Suggestions to overcame disparities in healthcare for the LGBTQIA+ populations.

that nevertheless are recognized and monitorized with the aim of improving itself.

With all its limitations Society in US remains among the most legally and culturally advanced for minority rights and this has a positive effect on helthcare processes even within the limits of its healthcare system. Here most of the studies and funds for research and stimulus for the international community. The USA always offers a variety of resources, ex.: https://www.cdc.gov/lgbthealth/health-services.htm.

The American College of Physicians in 2015 published the second edition of The Fenway Guide to LGBT Health, the first medical textbook focused on primary care for LGBTQIA+ people. The universal healthcare system is certainly a protection for everyone's health, especially for the most economically disadvantaged people and is therefore effective in conditions of intersectionality in which belonging to the LGBTQIA+ community is associated with other conditions of disadvantage, mainly of an economic nature.

It is a system that wants to guarantee equal care for everyone but does not necessarily have particular regard for minorities.

There are studies demonstrating that LGBTQIA+ minorities are not protected by the universalistic system, because other types of barriers prevail [10,11].

Furthermore, we should recognized the role of governmental and non-governmental-organizations in helping to overcame these disparities, providing dedicated programs for screening and care over the years.

The first big impulse in this sense comes from the past: the spread of HIV infection has created cohesion in communities, made people feel the need to affirm rights and provide responses to prevention and treatment needs. Attention to the need for health responses in their communities has renewed certain models and makes an important contribution to the development of dedicated healthcare programs. Organizations that deal with the health of LGBTQIA+ people have multiplied over time and are increasingly widespread throughout the world and renewed to date to offer a service for all current LGBTQIA+ communities health needs.

In US most Universities have Student Health Services committed to providing confidential, quality care in a safe and friendly environment, for LGBTQIA+ students, as well as have specific training programs for doctors and healthcare professionals.

However, as we know, health is a universal good and states cannot delegate its protection to others.

2. Discrimination and stigma enemies of health

Unfortunately still in 2023 there are many countries (64 UN member States) where is illegal to be LGBTQIA+ and in some of these death penalty is a possibility! In some countries, instead of improving, the situation becomes even more dramatic as recently happened in Russia. Decision-makers in many countries in the OECD, Latin America and Eastern Europe, to tackle LGBTQIA+ discrimination and exclusion are successfully expanding inclusive public policies.

Public health is threatened by all forms of discrimination, from verbal and or behavioral micro-aggressions, from half-hidden blame to the most violent and blatant forms of aggression and contempt.

Covert microaggression can often be the most dangerous, because it is more difficult for the performer to recognize and admit. Performers, almost always, do not realize its hostile, insulting, blameworthy or non-welcoming effect. These are the most frequent and reported forms of microaggressions that marginalized groups complain [12]. These effects compromise the health of the people and represent one of the main obstacles to achieving full health goals for all. The LGBTQIA+ is one of the population that more likely face routine microaggressions [13].

These negative experiences, especially if they come from the System designed to protect and guarantee your health, keeps people away, create distrust, make people refuse proposals and advice to improve your health and participate in prevention, vaccination and screening plans of diseases and on the contrary, induces maladaptive reactions which are instead important risk factors for diseases such as a disorderly life with little exercise, sleep disturbances, unhealthy diet and being overweight, smoking, substance use, alcohol abuse etc.

3. The variety of the LGBTQIA+ world corresponds to a multiplicity of needs and health related risks

Each gender identity and sexual orientation has its own cluster of risk factors and healthcare needs. For example specifically we note that trans healthcare can be very different and separate from LGBTQIA+ community health issues generally [14].

This is a fact confirming the need to have the ability to acquire data with extreme sensitivity so as to be able to identify the many different varieties of these populations and to detect all the possible intersectionalities influencing the state of health.

This certainty is the reason that should push each of us to openly talk with our healthcare provider about our gender identity and sexual behaviors.

It is an hard but necessary step to ensure the right care in the right place. This will be possible once we find a trusting and knowledgeable clinician.

Only a frank and profound relationship on both sides will allow the most appropriate treatments to be obtained at the right time and for the best outcome: from the early recognition of gender dysphoria, to targeted prevention and screening in different groups for specific forms of cancer or sexually transmitted diseases, from behavioral and lifestyle disorders that can undermine the health state to the psychological suffering that often accompanies and exacerbates unrecognized or misunderstood conditions and or emerge as the result of aggressions or microaggressions determining marginalization and discrimination up to the specificity of care for the elderly, frail and lonely LGBTQIA+ population.

4. Training for acquiring LGBTQIA+ cultural competence

A place with a culture of diversity and inclusion is more likely going to be able to share that positive experience with patients served and offering culturally sensitive and competent care for LGBTQIA+ populations. Creating such environments require training for all staff, not just clinicians.

Several studies show that training for healthcare professionals on specific LGBTQIA+ issues is lacking and that a growing number of students, postgraduates, generalists and specialists recognize the inadequacy of their knowledge and request and seek specific training [15].

5. The need for a better, more sensitive and deep communication

Getting in touch, being welcoming, knowing how to listen, knowing how to communicate, using a respectful and appropriate language, having sensitivity, are the essential elements to rebuild a relationship of trust that has often disappointed or lacked in recent years.

We need to find the language and the method to communicate bidirectionally with the communities of the excluded, to make them actors of the healthcare process.

Operators and users should be helped to meet, welcome each other, understand each other and have mutual trust in order to break down any type of barrier to fair treatment [16]. Health professionals still regret the lack of preparation on these issues in their curriculum and claim it, while users often suffer from a lack of attention and understanding for their specific needs so that these two worlds find it difficult to meet.

6. The need for reinvigorated educational, cultural, social and political action

Our societies still have an urgent need for communicative,

educational, cultural, social and political interventions to open up, understand and fully integrate into our communities all types of minorities, marginalized and struggling populations. We must transform the slogan "health for all" into a reality that is understood, accepted and shared by all. These interventions must be widespread and touch every area and every segment of the population: families, schools, the work environment, the world of associations, religious communities and every type of human aggregation.

Politics cannot betray these objectives of social justice and must realistically favor in every way the removal of all the obstacles that prevent a dignified, inclusive and equitable response to the health needs of the LGBTQIA+ populations.

However, while acknowledging a basic cultural problem of equity and inclusiveness in our societies, all the institutions appointed to provide health, from politics to hospitals, prevention and health centers, universities, research centers, up to all individual operators in the healthcare system, must impose an acceleration and become promoters and protagonists of a change capable of looking at, addressing, welcoming and dealing with every disadvantaged population by identifying their specific needs and offering the same opportunities for prevention and treatment to all.

7. Sexual orientation and gender identity data collection is a priority to address health inequities

Most of our health systems are still conceived according to an exclusively binary classification of biological sex of the population and this is a major significant weakness in providing equitable healthcare.

One of the most important limitations for adequate and tailored healthcare in the LGBTQIA+ population is the lack of certain data.

Successfully collecting, recording, storing and using accurate GSSO data is key to ensuring that any health inequality for all SGM is overcome. There is a lot of work to be done to create digital health systems that respectfully, safely, accurately and fully incorporate modernized GSSO data [17].

Currently, most digital health system lack the ability to properly capture and handle these information, possibly leading to inaccurate and potentially harmful clinical care.

The inappropriate selection of reference ranges can be a possible consequence.

Prevention cannot ignore the existence of specific population groups that instead require engaging, communication, educational, behavioral, screening and treatment tailored services in relation to their unique characteristics and needs.

GSSO data empowers to learn about the different populations and to measure access to care and quality of care provided to each subset of the multifaceted LGBTQIA+ galaxy.

8. Enhance specific LGBTQIA+ research

Despite the proliferation of scientific publications on the topic, we lack effective LGBTQIA+ -specific research in several areas of medicine. Data unavailability inhibit quantification of disparities and progress to their elimination. Further consequence is the absence of tailored clinical guidelines for prevention, screening or treatment protocols [3]. SGM populations should be included in clinical studies and trials. Complex analyses of multiply marginalized SGM groups are feasible. A recent study partnering with volunteer participants, contradicting most of the literature data available to date, reveals that SGM groups have fewer odds of cardiovascular and kidney disease, diabetes and hypertension while confirms a higher prevalence of depression, anxiety and HIV diagnosis. The results of this study are encouraging and may represent a model for addressing the gap in the health needs of this ubiquitous, ever-present and growing proportion of the population [18]. Most studies investigating the association between sexual orientation and mortality have been conducted in the USA. Recently a research conducted in Sweden showed a higher mortality for bisexual men and women, but not for homosexual men and women, compared to heterosexual men and women and the Authors suggest an influence of the juridical and socio-cultural situation on these results, hypothesizing possible higher mortality for both bisexuals and homosexuals in other countries with legal and social change which differ from Sweden [19].

Applying community-engaged strategies may be of critical importance in SGM research. It means to include with equal partnerships in study design decisions to promote and retain study participation, the populations of interest across the study leadership, community advisory boards, various stakeholder boards, research staff, and key personnel.

9. Conclusion

A complex picture of SGM health with health disparities and emerging new health concerns are unfortunately reported almost everywhere in the world.

In this context, we would like to emphasize how it is necessary to achieve health equity and inclusiveness at the global level, no minority and/or marginalized subpopulation can be overlooked while also remembering that in certain recesses, marginality and discrimination add up and that the invisibility of certain populations represents a serious vulnus for our entire society. In this regard and from this perspective, SGM should not be overlooked. SGM membership not infrequently intersects with ethnic and racial discrimination. Many economic, social, cultural, and health aspects unite all minorities and are amplified in those groups that identify with multiple conditions of marginalization and discrimination [3].

We need to develop new and innovative approaches to increase the reach and effectiveness of evidence-based public health strategies in populations and communities with a high burden of chronic diseases optimizing health status and social equity.

Healthcare providers, public health systems, and community partners can work together to increase enrollment in lifestyle-change programs of people disproportionately affected by chronic diseases.

WHO recently announced the development of a guideline on the health of trans and gender diverse people and this could be a further opportunity to guide us and solicit the commitment to ensure health and well-being for all.

However, the clear and conclusive message is that all this cannot be realized until we are finally able to have certain health data on the LGBTQIA+ populations.

This is a focal and priority point. It is urgent to adapt the collection data systems [20] currently frozen in almost all of the world to a binary male/female distinction, raise awareness among operators (health professionals, administrators, doctors, researchers) on this issue and urge citizens/patients not to be afraid of reveal their sex/gender/sexual orientation data as long as this can happen in a welcoming and safe context.

Funding

No funding was received for this work.

Declaration of competing interest

The authors declare they have no conflict of interest.

References

[1] Daniel H, Bornstein SS, Kane GC, , Health and Public Policy Committee of the American College of Physicians, Carney JK, Gantzer HE, et al. Addressing social determinants to improve patient care and promote health equity: an American college of physicians position paper. Ann Intern Med 2018;168(8):577–8. https://doi.org/10.7326/M17-2441. Apr 17.

[2] Scout N. Unique issues facing sexual and gender minorities in cancer. Cancer Discov 2023;13(6):1297–300. https://doi.org/10.1158/2159-8290.CD-23-0455. Jun 2.
[3] Fredriksen-Goldsen KI, Kim HJ, Shui C, Bryan AEB. Chronic health conditions and key health indicators among lesbian, gay, and bisexual older US adults, 2013-2014. Am J Public Health 2017;107(8):1332–8. https://doi.org/10.2105/AJPH.2017.303922. Aug.
[4] Streed Jr CG, Knight K, Kimball SL. Sexual and gender minority refugees - preparing clinicians for the international anti-LGBTQI+ crisis. N Engl J Med 2023;389(9):778–81. https://doi.org/10.1056/NEJMp2305401. Aug 31.
[5] Sirufo MM, Magnanimi LM, Ginaldi L, De Martinis M. Overcoming LGBTQI+ disparities in cardio-oncology: a call to action. JACC Cardio Oncol 2023;5(2):267–70. https://doi.org/10.1016/j.jaccao.2022.11.017. Mar 7.
[6] Sirufo MM, Ginaldi L, De Martinis M. The intersection of sexual identity with race and ethnicity in allergic diseases. J Allergy Clin Immunol Pract 2023;11(3):973–4. https://doi.org/10.1016/j.jaip.2022.12.031. Mar.
[7] Sutha K, Streed Jr CG. Including sexual orientation and gender identity data to advance nephrology care. Nat Rev Nephrol 2023;19(6):355–6. https://doi.org/10.1038/s41581-023-00712-1. Jun.
[8] Sirufo MM, Magnanimi LM, Ginaldi L, De Martinis M. Chronic obstructive pulmonary disease in the LGBTQI+ population. Ann Am Thorac Soc 2022;19(12):2111–2. https://doi.org/10.1513/AnnalsATS.202207-653LE. Dec.
[9] Sirufo MM, Magnanimi LM, Ginaldi L, De Martinis M. Frailty prevention and management in the LGBTQI+ population. Maturitas 2023;169:53. https://doi.org/10.1016/j.maturitas.2022.07.019. Mar.
[10] Lavorgna L, Moccia M, Russo A, Palladino R, Riccio L, Lanzillo R, Brescia Morra V, Tedeschi G, Bonavita S. Health-care disparities stemming from sexual orientation of Italian patients with multiple Sclerosis: a cross-sectional web-based study. Mult Scler Relat Disord 2017;13:28–32. https://doi.org/10.1016/j.msard.2017.02.001. Apr.
[11] Marti-Pastor M, German D, Perez G, Bartoll X, Diez E, Pont A, Garín O, Alonso J, Hernandez G, Mayoral K, Zamora V, Vilagut G, Ferrer M. Health inequalities by sexual orientation: results from the 2016-2017 barcelona health survey. LGBT Health 2022;9(7):496–511. https://doi.org/10.1089/lgbt.2021.0171. Oct.
[12] Pease M, Williams ND, Iwamoto DK, Salerno JP. Minority stressors and their associations with severe psychological distress among gender-diverse people. Am J Orthopsychiatry 2022;92(5):578–89. https://doi.org/10.1037/ort0000635.
[13] Salerno JP, Pease MV, Gattamorta KA, Fryer CS, Fish JN. Impact of racist microaggressions and LGBTQ-related minority stressors: effects on psychological distress among LGBTQ+ young people of color. Prev Chronic Dis 2023;20:E63. https://doi.org/10.5888/pcd20.220371. Jul 20.
[14] Crowe S, Barker E, Roberts M, Lloyd L, de Barros CM, Rebelo-Harris B, Meads C, Saunders CL. Are we asking the right questions? Working with the LGBTQ+ community to prioritise healthcare research themes. Res Involv Engagem 2021;7(1):64. https://doi.org/10.1186/s40900-021-00298-7. Sep 24.
[15] Ard KL, Keuroghlian AS. Training in sexual and gender minority health - expanding education to reach all clinicians. N Engl J Med 2018;379(25):2388–91. https://doi.org/10.1056/NEJMp1810522. Dec 20.
[16] Mitchell LA, Jacobs C, McEwen A. (In)visibility of LGBTQIA+ people and relationships in healthcare: a scoping review. Patient Educ Couns 2023;114:107828. https://doi.org/10.1016/j.pec.2023.107828. Sep.
[17] Queen R, Courtney KL, Lau F, Davison K, Devor A, Antonio MG. What's next for modernizing gender, sex, and sexual orientation terminology in digital health systems? Viewpoint on research and implementation priorities. J Med Internet Res 2023;25:e46773. https://doi.org/10.2196/46773. Jul 25.
[18] Streed Jr CG, Lett E, Restar A. Assessing the health status of sexual and gender minority adults: what we can learn when we include all of us. JAMA Netw Open 2023;6(7):e2324948. https://doi.org/10.1001/jamanetworkopen.2023.24948. Jul 3.
[19] Lindström M, Rosvall M. Sexual orientation and all-cause mortality: a population-based prospective cohort study in southern Sweden. Public Health Pract (Oxf) 2020;1:100032. https://doi.org/10.1016/j.puhip.2020.100032. Jul 12.
[20] Ginaldi L, De Martinis M. Modernizing gender, sex, and sexual orientation data through engagement and education. J Med Internet Res 2023;25:e51632. https://doi.org/10.2196/51632. Nov 15.