STRUCTURAL STIGMA AND SEXUAL ORIENTATION DISPARITIES IN HEALTHCARE USE

EVIDENCE FROM CENSUS-LINKED-ADMINISTRATIVE DATA

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BACKGROUND & MOTIVATION

- The sexual and gender diverse community have worse health outcomes than their heterosexual/cis counterparts:
  - Acute, chronic conditions & mental health (AOD, self harm, suicide) (Booker et al., 2017; Conron et al., 2010; Landers & Gilsanz, 2009; Sandfort et al., 2006) (Perales, 2016 (Soc. ind. Res); Perales & Todd (SS&M), 2018; Daraganova, 2017).

- Key contributor: stress associated with structural stigma

- May contribute to these health inequalities by inducing:
  - psychopathological stress responses
  - risky health behaviours (AOD) and
  - reduced healthcare seeking

- Numerous studies outlining the negative health effects of structural stigma

- Limited population-level information on how this stigma affects objective healthcare and medicine use
MINORITY STRESS THEORY

- Leading conceptual framework explaining sexual minority health disparities
- Sexual minorities people experience unique & chronic stress because of negative social attitudes and prejudice

Distal:
- Abuse
- Victimisation
- Discrimination

Proximal:
- Internalised homophobia & stigma
- Concealment

Structural stigma contributes to health inequalities but what about healthcare use? → AIM
STRUCTURAL STIGMA: MARRIAGE EQUALITY SURVEY

• Postal survey on same-sex marriage:
  - 12<sup>th</sup> September - 7<sup>th</sup> November 2017

• 80% of all eligible Australians participated in survey

Results: 61.6% thought the law to be changed to allow same-sex couples to marry (ABS, 2017)
STRUCTURAL STIGMA: MARRIAGE EQUALITY SURVEY RESULTS BY SA2
DATA:
MULTI-AGENCY DATA INTEGRATION PROJECT, BASIC LONGITUDINAL EXTRACT 2011-2016 (2011-2016 COHORTS)

2016 Census linked to admin data 2011 – 2016
~75% of 2016 Australian Census population

Census info:
- Sociodemographic & household information → in same-sex / heterosexual relationship
- Location down to SA2 level (~10,000 per SA2)

Admin data (2011-2016):
- Tax, SSRI data
- Medicare data from
  - Government subsidised medical services & prescription medicines
  - 9 healthcare service subgroups, 14 medicine subgroups
    - GP
    - Nervous system (antidepressants)
    - Pathology services & anti-infectives (sexual health checks & HIV-related medication)
EMPIRICAL STRATEGY

- **Aim**: Extent structural stigma is associated with sexual orientation disparities in healthcare and prescription medicine use
- Mapping “votes against same-sex marriage” from the 2017 Marriage Equality Survey to admin data

**Regression model**: interact structural stigma with sexual orientation & gender

\[ y_{irt} = \alpha + \beta_1 HF_i + \beta_2 SSF_i + \beta_3 SSM_i + \beta_4 (HF_i \times S_r) + \beta_5 (HM_i \times S_r) \]

\[ + \beta_6 (SSF_i \times S_r) + \beta_7 (SSM_i \times S_r) + \beta_i \hat{IC}_i + \beta_k \hat{IC}_{it} + \nu_t + \varepsilon_{ir} + u_r \]

Healthcare service
OR
Prescription medicine

Differences between indiv. het and same-sex relationships in average stigma …..

…then estimate whether these disparities change as regional % no votes increases

Regional fixed effects (SA2 level)
- Unobservables specific to region

Controls:
- age, income, labour force status
- year fixed effects
## Model Estimation Results

<table>
<thead>
<tr>
<th>Probability of visiting a GP</th>
<th>In ‘average’ stigma region (38% no votes):</th>
<th>10% absolute increase in no votes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female in same-sex relationship ( (\beta_2) ) (ref: Female in heterosexual relationship)</td>
<td>Female in same-sex relationship ( (\beta_5) ) (ref: Female in heterosexual relationship)</td>
</tr>
<tr>
<td></td>
<td>(-0.029^{***}) [-0.034;-0.025]</td>
<td>(0.002) [-0.001;0.006]</td>
</tr>
<tr>
<td></td>
<td>Male in same-sex relationship ( (\beta_3) ) (ref: Male in heterosexual relationship)</td>
<td>Male in same-sex relationship ( (\beta_6) ) (ref: Male in heterosexual relationship)</td>
</tr>
<tr>
<td></td>
<td>(0.031^{***}) [0.025;0.036]</td>
<td>(-0.016^{***}) [-0.020;-0.013]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>32,956,488</th>
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<tr>
<td>Mean of outcome</td>
<td>0.803</td>
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</table>

**Controls:** age, labour force status, income, move 1 year ago / 5 years ago, education, regional and year fixed effects
RESULTS: ANNUAL GP VISITS AND NERVOUS SYSTEM SCRIPTS

Difference in use compared to heterosexual counterparts

- In same-sex female relationship
- In same-sex male relationship

Average stigma (38% no votes) 10% increase in no votes (48% no votes)

→ Full set of observable confounders plus region FE controlled for
**Other Findings**

- **Heterogeneity:**
  - low income, less years of education, less access to healthcare

- **Men in SSR use less** *pathology-related* items & *anti-infective* medication
  - HIV medication, services rel. sexual health checks

- **Stigma & worse health:**
  - Core activity limitations and DSP
CONCLUSIONS

- LG individuals in more stigmatised regions in poorer health, use more mental health related medications but use fewer primary health services
- Men in SSR use less sexual health related services
- Suggest structural stigma may impact mental health of LG community and increased discomfort in engaging with HCPs

- Ongoing work to reduce health & healthcare access disparities in SMs
- Highlights need for interventions inclusive practices in primary care setting
ACKNOWLEDGEMENTS

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Findings based on the use of ABS Microdata.

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