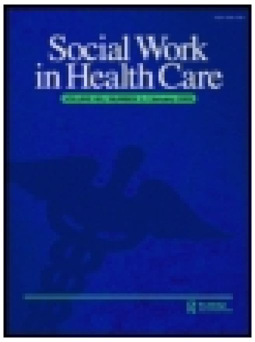

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Profound health-care discrimination experienced by transgender people: rapid systematic review

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ABSTRACT

Transgender people experience interpersonal and structural barriers which prevent them from accessing culturally and medically competent health care. This rapid systematic review examined the prevalence of health-care discrimination among transgender people in the U.S. and drew comparisons with sexual minority samples and the general U.S. population. Eight primary studies with 35 prevalence estimates were analyzed. Transgender populations experience profound rates of discrimination within the U.S. health-care system. Compared to sexual minorities, transgender participants appear to be more compromised in their access to health care. Service providers must change structural inequities which contribute to transgender people's invisibility.

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Cisgenderism; cisnormativity; health-care access; health-care discrimination; rapid systematic review; trans*; transgender

The term *transgender* is "widely used to refer to a diverse group of individuals who cross or transcend culturally defined categories of gender" (Bockting, 1999 as cited in Institute of Medicine, 2011, p. 26). It is an "umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Transgender people may or may not decide to alter their bodies hormonally and/or surgically" (National Resource Center on LGBT Aging, 2012, p. 27). Recent data from a population-based survey suggests that 0.6% of adults in the U.S. (approximately 1.4 million people) identify as transgender (Flores, Herman, Gates, & Brown, 2016). Transgender health needs are beginning to draw attention from health-care providers and researchers, with many practitioners and health-care systems finding themselves ill equipped to meet the needs of transgender populations (Lombardi, 2001). Transgender people are a medically underserved population experiencing pervasive discrimination in the health-care system (Giblon & Bauer, 2017; Rodriguez, Agardh, & Asamoah, 2017). As advocates for social justice, social workers need to understand the barriers which prevent transgender people from accessing medically and culturally competent care.

As a marginalized population, transgender people experience pervasive discrimination in almost every institution and system in their lives. Social research

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has revealed the many facets of their oppression, all of which have deleterious effects on transgender individuals' health and well-being (Albuquerque et al., 2016; Brandes, 2014; Grant et al., 2011; James et al., 2016; McCann & Brown, 2017; Winter et al., 2016). The rates of homelessness and poverty, along with disparities in health and education, contribute to the body of evidence regarding housing and employment inequities that they experience and their barriers to access within health-care and school systems (Grant et al., 2011; James et al., 2016; Winter et al., 2016). Acts of violence and victimization committed against them are often spurred by transphobia (i.e., irrational fear or hatred of transgender people). Many of these crimes remain unreported, as trans individuals are often fearful of further victimization from police officers and discrimination within the criminal justice system (Grant et al., 2011; James et al., 2016; Moolchaem, Liamputtong, O'Halloran, & Muhamad, 2015; Winter et al., 2016). Because of their poverty, many trans individuals participate in the underground economy for survival which places them at further risk for health and legal problems (Grant et al., 2011; James et al., 2016; Moolchaem et al., 2015). This interlocking web of inequities produces and reproduces the social exclusion which sustains their oppression (Grant et al., 2011; James et al., 2016).

While transphobia is often used to explain the direct acts of discrimination and violence committed against trans people on an individual level, this singular focus obscures the systemic social exclusion which occurs at the structural or institutional level, and entrenched within cultural and political contexts (Bauer et al., 2009; Namaste, 2000; Pyne, 2011). The concept of erasure has been used to explain the interlocking systems of oppression which render transgender people invisible and ultimately undermines the possibility of a trans identity (Namaste, 2000). Bauer et al. (2009) advanced this concept further by explaining how erasure manifests within the health-care environment through informational systems and institutional policies and practices.

Knowledge production impacts information dissemination. Informational erasure refers to the lack of knowledge produced about trans people and maintaining the assumption that such knowledge is non-existent even when there is evidence to counter this assumption (Bauer et al., 2009). For example, health researchers often hold an erroneous assumption that all research participants are cisgender (people whose gender identity aligns with their assigned sex at birth) and thus the questions which are .important to trans people are never brought into focus. This contributes to the lack of information about trans-specific health issues in educational curricula and textbooks. When information about trans people is included, it is often integrated into lesbian, gay, bisexual, and transgender (LGBT) issues, thereby conflating gender identity with sexual orientation and obscuring the specific needs of the transgender population. The paucity of research resulting in a dearth of information renders health-care providers poorly equipped to handle the health needs of their trans patients. Many trans individuals find themselves having to educate their health-care providers about their needs. Therefore, informational erasure maintains their invisibility and social exclusion (Bauer et al., 2009; Cruz, 2014; Reisner et al., 2014).

Institutional erasure manifests as policies or organizational infrastructure which exclude the existence of trans identities or trans bodies. Examples include intake forms which utilize a binary categorization for sex/gender, settings which use sex segregation as part of their provision of service (e.g., hospital wards, shelters, etc.), and billing systems which require concordance between listed sex and anatomy to allow for billing of sex specific procedures:

> … trans people are often forced to choose between accessing services according to their birth sex or foregoing services entirely… Broadly, trans people seeking health care are often faced with the acute realization that many providers are not familiar with or willing to accept the possibility of trans identities, which impacts both the availability and quality of care. Embedded in this particular configuration of institutional erasure is a politics of recognition regarding being in the appropriate place or possessing the correct anatomy to be provided service. (Bauer et al., 2009, p. 355)

Trans patients who have disclosed their gender identity have experienced active, direct discrimination from health-care providers such as the denial of care, abuse, or harassment (Fredriksen-Goldsen et al., 2011; Grant et al., 2011; James et al., 2016; Lambda Legal, 2010; Reisner et al., 2014). To avoid discrimination, many trans patients opt not to disclose their trans identity by passing as cisgender, or engage in selective disclosure based on their perception of the health-care provider's attitude, the setting, or the medical need. This complex disclosure process shapes the access to care and impact health outcomes (Bauer et al., 2009; Cruz, 2014). "Disclosure involves the risk of denial of care or mistreatment; lack of disclosure involves the risk of inappropriate health care and possible unintentional disclosure through medical examinations or testing" (Bauer et al., 2009, p. 357). The informational and institutional erasure can be both active and passive, and result in barriers to access which reinforce the marginalization of trans patients in their engagement with health-care systems.

Sadly, because of their lack of training on the needs of trans populations and trans health issues, many health-care providers reflect society's cisgenderist attitudes and cisnormative assumptions. Even if they do not align with cisgenderist ideology on an individual basis, health-care providers often work in broader social contexts which produce and perpetuate cisnormativity and cisgenderism at systemic and structural levels. Underpinned by transphobia and reinforced by erasure, cisnormativity fosters the assumption that all people are cisgender. These assumptions are so pervasive that health-care providers and institutions do not question the experience of gender, do not anticipate the possibility of a trans existence, and thus are unprepared when such a person seeks their services. Paradoxically, the invisibility of trans identities creates a sudden hyper-visibility when a trans patient enters the health-care system such that these situations are regarded as anomalies which challenge the process of medically and culturally competent service delivery (Bauer et al., 2009; Pyne, 2011).

Cisnormativity breeds cisgenderism which refers to the privileging of non-trans identities. Cisgenderism can occur through both unintentional and well-intentioned practices. Examples of cisgenderism may include (a) pathologizing (i.e., characterizing a person's gender identity as disordered); (b) misgendering (i.e., classifying individuals in a way that is inconsistent with their gender identity); (c) marginalizing (i.e., regarding a person's gender identity as weird or strange); (d) coercive queering (i.e., imposing a queer or LGBT label on trans people who identify as heterosexual and assuming that they have the same needs as those in same-gender relationships); and (e) objectifying biological language (i.e., using language which describes a person's assumed physical characteristics such as female-to-male or FTM) (Ansara, 2015). The conceptual lens of informational and institutional erasure, cisnormativity, and cisgenderism bring the systemic marginalization of trans identities into focus and confront the embodied privilege of the cisgender identity. It captures the nuances of discrimination and the system that empowers it, impacting transgender people's ability to access appropriate health care.

Health-care access is often characterized as the ability and ease of the consumer to seek and obtain needed services from providers or institutions, the cost of health care, and the characteristics of health-care providers which may impact service delivery. In their systematic review of access to health care, Levesque, Harris, and Russell (2013) conceptualized accessibility as consisting of the following dimensions: (a) approachability (e.g., information regarding available treatments and services, outreach activities, transparency, etc.); (b) acceptability (e.g., professional values and norms, sociocultural factors which impact the consumer's level of acceptance to aspects of the service, perceived appropriateness of the consumer seeking care, etc.); (c) availability and accommodation (e.g., geographic location of the service, hours of operation, building accessibility, presence and qualification of the health professional, modes of provision of services, etc.); (d) affordability (e.g., capacity of consumers to spend resources and time to utilize services, direct costs of services, indirect costs such as travel time, opportunity costs related to loss of income, etc.); and (e) appropriateness (e.g., the fit between the services and the consumers' needs, the technical and interpersonal quality of the services provided). Because of cisnormativity and cisgenderism, each of these dimensions of accessibility is compromised for trans communities. This can occur directly in the form of overt discrimination (such as a trans patient's experience of being denied care or receiving physical or verbal abuse from a health-care provider which are impediments to availability, acceptability, and appropriateness) or indirectly as a secondary outcome of discrimination in other systems (such as employment inequity resulting in lack of employer sponsored health insurance, thereby impacting affordability).

To explore evidence of transgender related discrimination in health care and the pervasive ways in which cisnormativity and cisgenderism impact health-care accessibility, the following research questions were formulated de novo for this rapid review:

(1) What is the prevalence of health-care discrimination among transgender people in the U.S.?
(2) Is the prevalence of health-care discrimination greater among transgender people compared to sexual minority group members or members of the general U.S. population?

Methods

Study procedures

Rapid review methods utilizing streamlined techniques were employed by a single investigator. This lessened the time required to complete this study from greater than 12 months to less than 6 months (Ganann, Ciliska, & Thomas, 2010; Tricco et al., 2015). Both peer reviewed and gray literature (i.e., non-peer reviewed research reports) were reviewed. Because of the scarcity of research on transgender populations coupled with their frequent subsummation within LGBT research, the following search terms were used: (LGBT or lesbian or gay or bisexual or transgender) and (health-care discrimination). This allowed for comparisons of prevalence rates between transgender participants and their LGB counterparts. Using the date frame of January 1, 2010 to June 15, 2018, the following electronic databases were searched: LGBT Life, Social Work Abstracts, Social Services Abstracts, Sociological Abstracts, PsycINFO, PubMed, ProQuest Dissertations and Theses Global, Web of Science^{TM} Conference Proceeding Citation Indexes—Science and Social Science & Humanities, and Google Scholar. In addition, searches were augmented with snowball searches of reference lists of retrieved articles or research reports. The search was limited to publications in English. Retrieved were 2470 conceptually relevant, duplicated manuscripts.

Subsequently, the studies had to meet the following inclusion criteria:

(1) The studies provided prevalence estimates of barriers to health-care access or health-care discrimination experienced by LGBT or transgender participants
(2) The studies were conducted in the U.S.

(3) The prevalence rates were obtained from national or state-specific samples

Only primary independent studies were selected; secondary analyses which examined the separate mediator or moderator relationships within the primary studies were excluded. Studies which examined the prevalence of health-care discrimination in other countries were excluded because the health-care system in the U.S. takes place within its own cultural, economic, and political milieu. Health-care access in the U.S. is dependent, in large part, on employer sponsored health insurance. Therefore, its infrastructure consists of processes and systemic barriers which may be different from that of other high-income countries. There were eight primary studies which met the inclusion criteria for this rapid review. They are noted in the reference section with an asterisk.

Analysis of prevalence estimates

Survey-based prevalence estimates of barriers to health-care access among transgender people were reviewed. A prevalence estimate is the proportion of a population exhibiting a certain condition or behavior within a given time-frame. Using Levesque et al.'s (2013) conceptual framework of health-care accessibility, nine variables were extrapolated from the eight studies which resulted in 35 prevalence estimates. The access barrier variables were: (a) being denied care; (b) medical providers' lack of knowledge or had to educate Primary Care Physician (PCP); (c) lack health insurance; (d) health-care professionals using harsh or abusive language; (e) health-care professionals being physically rough or abusive; (f) out to health-care provider about being transgender; (g) verbal harassment in a health-care setting; (h) physically attacked in a health-care setting; and (i) do not have a regular PCP. These variables exhibit the ways in which cisnormativity and cisgenderism manifest itself within the U.S. health-care system.

The prevalence estimates for each study sample were extracted from the eight primary studies and reported as percentages along with their normal 95% confidence intervals (CI) (Fleiss, Levin, & Paik, 2003). If a study examined the aggregated LGBT population and the transgender subpopulation, these were estimated separately. Some of the studies provided prevalence estimates of general populations. This offered an opportunity to draw comparisons and highlight disparities between transgender and general (state) populations.

Medians were used in describing the prevalence outcomes of trans people's experience of health-care access barriers. The chi-square statistic (χ^2) was used to calculate the statistical significance of the comparison between the transgender population and their LGB counterparts; most of these comparisons occurred between samples within the same study. Prevalence ratios (PR) and the 95% CI derived from χ^2 tests were used to report the practical significance of the between group comparisons of the transgender population and their LGB counterparts within the same study sample or the U.S. general population as referenced within the primary study (Fleiss et al., 2003). A PR is the ratio of one group's prevalence estimate to another group's prevalence estimate. PR values greater than 1.00 reflect a trans disadvantage. The difference between two groups was considered statistically significant ($p < 0.05$) when the 95% CI did not include the null value of 1.00. Because the studies varied in their measurement of prevalence over a temporal period (i.e., lifetime prevalence versus prevalence within the past 12 months), medians and PR values were calculated only when the researchers used the same temporal period in measuring prevalence.

Results

Sample description

Surveys from an aggregated sample of 43,570 lesbian, gay, bisexual, transgender, questioning (individuals who are still in the process of exploring and discovering their sexual orientation, gender identity, and gender expression), and intersex (individuals whose sexual anatomy or chromosomes do not fit the traditional markers of male and female) respondents were collected over the eight studies. Four of the surveys were in specific states: Virginia (Bradford, Reisner, Honnold, & Xavier, 2013), Colorado (One Colorado, 2014), Massachusetts (Reisner et al., 2014), and Hawaii (Stotzer, Ka'Opua, & Diaz, 2014). The remaining samples were drawn nationally. Five of the studies were exclusively transgender. The remaining studies surveyed the LGBT population—one of which included questioning and intersex respondents in their sample. Given the difficulty in accessing the sexual and gender minority populations, all the studies used a non-probability sampling method (i.e., convenience, snowball, or respondent driven sampling). All the studies used online methods and all except one study augmented these with hard copy questionnaires or personal interviews. Two of the studies were published in peer reviewed journals (Bradford et al., 2013; Stotzer et al., 2014) while the rest were non-peer reviewed research reports (Fredriksen-Goldsen et al., 2011; Grant et al., 2011; James et al., 2016; Lambda Legal, 2010; One Colorado, 2014; Reisner et al., 2014).

Barriers to health-care accessibility

Many transgender people reported having negative experiences when interfacing with the health-care system. As can be seen in Table 1, over a quarter of the transgender people studied had been denied care by a health-care professional at least once in their lifetimes (19–40%,

Table 1. Summary of studies on health care discrimination and access barriers against sexual and gender minorities: Prevalence estimates with 95% confidence intervals (CI).

	Sample				PR
Study Citation	Description	Size	Prevalence Estimate (%)	95% CI	95% CI
Availability and Accommodation					
Being denied care					
Lambda Legal (2010)	Transgender	700	26.7[a]	23.6, 30.1	3.47
Lambda Legal (2010)	LGB	4,722	7.7[a]	7.0, 8.5	2.95, 4.08
Fredriksen-Goldsen et al. (2011)	Transgender	174	40.4[a]	33.2, 47.7	3.85
Fredriksen-Goldsen et al. (2011)	LGB	2,386	10.5[a]	9.4, 11.8	3.06, 4.84
Grant et al. (2011)	Transgender	6,450	19.0[a]	18.1, 20.0	
James et al. (2016)	Transgender	24,112	8.0[b]	7.7, 8.4	
Reisner et al. (2014)	Transgender	452	5.0[b]	3.4, 7.5	
Stotzer et al. (2014)	LGBTQI	710	15.0[a]	12.6, 17.9	
Medical providers' lack of knowledge or had to educate PCP					
Grant et al. (2011)	Transgender	6,450	50.0[a]	48.8, 51.2	
Bradford et al. (2013)	Transgender	350	20.0[a]	16.2, 24.5	
James et al. (2016)	Transgender	24,112	24.0[b]	23.5, 24.5	
Reisner et al. (2014)	Transgender	452	29.0[b]	25.0, 33.3	
Affordability					
Lack health insurance					
One Colorado (2014)	Transgender	417	14.0	10.9, 17.6	1.27
One Colorado (2014)	All Coloradans[c]	Not available	11.0		
Stotzer et al. (2014)	LGBTQI	710	11.1	8.9, 13.5	
Grant et al. (2011)	Transgender	6,450	19.0	18.1, 20.0	
James et al. (2016)	Transgender	27,715	14.0	13.6, 14.4	
Fredriksen-Goldsen et al. (2011)	LGBT	2,560	3.0	2.4, 3.8	
Appropriateness					
Health care professionals using harsh or abusive language					
Lambda Legal (2010)	Transgender	700	20.9[a]	18.0, 24.0	1.95
Lambda Legal (2010)	LGB	4,722	10.7[a]	9.8, 11.6	1.65, 2.30
James et al. (2016)	Transgender	24,112	5.0[b]	4.7, 5.3	
Health care professionals being physically rough or abusive					
Lambda Legal (2010)	Transgender	700	7.8 [a]	6.1, 10.1	1.90
Lambda Legal (2010)	LGB	4,722	4.1 [a]	3.6, 4.7	1.43, 2.52
James et al. (2016)	Transgender	24,112	2.0 [b]	1.8, 2.2	
Acceptability					
Out to health care provider about being transgender					
Bradford et al. (2013)	Transgender	350	43.3	38.3, 48.7	
Grant et al. (2011)	Transgender	6,450	79.0	78.0, 80.0	
James et al. (2016)	Transgender	27,715	70.0	69.5, 70.5	
Verbal harassment in a health care setting					
Grant et al. (2011)	Transgender	6,450	28.0[a]	26.9, 29.1	
James et al. (2016)	Transgender	24,112	6.0[b]	5.7, 6.3	
Physically attacked in a health care setting					
Grant et al. (2011)	Transgender	6,450	2.0[a]	1.7, 2.4	
James et al. (2016)	Transgender	24,112	1.0[b]	0.8, 1.1	
Approachability					
Do not have a regular PCP					
Bradford et al. (2013)	Transgender	350	40.0	35.0, 45.2	
Stotzer et al. (2014)	LGBTQI	710	27.4	24.3, 30.9	

(*Continued*)

Table 1. (Continued).

	Sample				PR
Study Citation	Description	Size	Prevalence Estimate (%)	95% CI	95% CI
Stotzer et al. (2014)	All Hawaiians[d]	Not available	17.2		
Fredriksen-Goldsen et al. (2011)	LGBT	2,560	6.0	5.2, 7.0	

Note. PR = Prevalence Ratio between transgender and comparison group. CI = Confidence Interval. LGB = Lesbian, gay, bisexual. LGBTQI = Lesbian, gay, bisexual, transgender, questioning, intersex. LGBT = Lesbian, gay, bisexual, transgender. PCP = Primary Care Physician

[a]Lifetime prevalence. [b]Prevalence in the last 12 months. [c]Gallup. [d]Institute of Medicine.

median = 27%). When the samples who experienced a lifetime prevalence of being denied care were aggregated (Fredriksen-Goldsen et al., 2011; Grant et al., 2011; Lambda Legal, 2010), results reveal that transgender individuals were more than twice as likely as their LGB counterparts to be denied care, χ^2 (1, N = 14,432) = 390.44, $p < 0.05$, PR = 2.34 (95% CI 2.15, 2.55). Between group comparisons within the same study show an even greater disadvantage: Lambda Legal (2010) and Fredriksen-Goldsen et al. (2011) show that transgender individuals were over three times more likely to be denied care than their LGB counterparts. Over a third of the transgender participants had encounters with health-care professionals who were not informed about trans related health issues and had to teach these providers about their health needs to receive appropriate care (20–50% lifetime prevalence, median = 35%). Approximately one in seven transgender individuals do not have health insurance (14–19%, median = 14%). When compared to the general population, transgender people were 27% more likely to lack health insurance (PR = 1.27). Counter to their professional values and ethics, health-care providers often treat transgender people harshly, either in the form of verbal or physical abuse. Within the past 12 months of the survey, 1 in 20 transgender individuals had experienced health-care providers using harsh or abuse language toward them and 1 in 50 such individuals had received physically rough or abusive treatment. Compared with their LGB counterparts, transgender people were almost twice as likely to have been verbally abused: 20.9% versus 10.7%, χ^2 (1, N = 5,422) = 59.59, $p < 0.05$, PR = 1.95 (95% CI 1.65, 2.30). Transgender people were also twice as likely to have been physically abused by their health provider: 7.8% versus 4.1%, χ^2 (1, N = 5,422) = 19.55, $p < 0.05$, PR = 1.90 (95% CI 1.43, 2.52). Over two-thirds of the transgender population have disclosed their gender identity to their health provider (43–79%, median = 70%). This means that almost one in three transgender individuals have chosen not to disclose their gender identity which may result in a compromised ability to receive appropriate treatment. Finally, the study by Stotzer et al. (2014) showed that sexual and gender minorities, in general, were more likely to lack a regular physician compared to the general state population. More specifically, 40% of transgender people were estimated to not have a regular PCP (Bradford et al., 2013). Considering their negative experiences with health-care providers, it is not surprising, then, that almost one-quarter of transgender people have delayed receiving necessary medical care (19–40%, median = 23%) and preventive medical care (24%) in the past 12 months (Table 2).

Discussion

LGBT advocates have made some advancements in creating visibility and demanding equity. There is, however, still a long road to establishing inclusivity—especially within heteronormative and cisnormative health-care systems. Although the experience of discrimination may be common among LGBT individuals because of their minority status, the results of this rapid review provide evidence of transgender people's consistent disadvantages in accessing health care. They are a highly marginalized subgroup within the LGBT community, experiencing health-care discrimination at higher rates than their LGB cohorts. These results substantiate the heterogeneity of the LGBT population and reaffirm the need to increase health-care providers' understanding of the unique needs of transgender people.

Other systematic reviews of the empirical research have revealed the discrimination and social exclusion experienced by transgender individuals generally (McCann & Brown, 2017; Moolchaem et al., 2015), their interface with the health-care system more specifically (Lerner & Robles, 2017), and their increased vulnerability at the end of life in particular (Kcomt & Gorey, 2017). Moreover, researchers have discovered that among the LGBT

Table 2. Summary of studies on patient postponement of medical care: Prevalence estimates with 95% confidence intervals (CI).

	Sample			
Study Citation	Description	Size	Prevalence Estimate (%)	95% CI
Patient postponement of necessary medical care				
Grant et al. (2011)	Transgender	6,450	28.0 [a]	26.9, 29.1
James et al. (2016)	Transgender	24,112	23.0 [b]	22.5, 23.5
Reisner et al. (2014)	Transgender	452	19.0 [b]	15.7, 22.9
One Colorado (2014)	Transgender	417	40.0[b]	35.5, 44.8
Stotzer et al. (2014)	LGBTQI	710	10.0[a]	8.0, 12.4
Patient postponement of preventive medical care				
Grant et al. (2011)	Transgender	6,450	33.0 [a]	31.9, 34.2
Reisner et al. (2014)	Transgender	452	24.0 [b]	20.2, 28.0

Note. CI = Confidence Interval. LGBTQI = Lesbian, gay, bisexual, transgender, questioning, intersex.
[a]Lifetime prevalence. [b]Prevalence in the last 12 months.

population, transgender participants were more likely to report the negative effects of disclosure to their provider and thus were more likely to delay seeking health care than their cisgender LGB counterparts (Macapagal, Bhatia, & Greene, 2016). Additionally, their recognizability as a transgender person was significantly associated with their perceived discrimination in health care (Rodriguez et al., 2017). A significant relationship exists between delaying care because of fear of discrimination and worse general and mental health among transgender adults (Seelman, Colón-Diaz, LeCroix, Xavier-Brier, & Kattari, 2017). The avoidance of or delayed entry into health care can result in health disparities which contribute to morbidity and mortality.

Affordability and availability are important dimensions of health-care access. Within the interlocking web of oppression, transgender people may experience employment based discrimination and financial inequities which impact their ability to have health insurance or pay for the direct and indirect costs of health care. Moreover, finding a trans-affirming health-care provider within reasonable proximity can be challenging (Grant et al., 2011; James et al., 2016). The lack of health insurance and the unavailability of trans-affirming health care can have a direct impact on health outcomes. For example, unable to obtain hormone therapy through a health-care provider, a trans person may resort to using street hormones which can have dire consequences (White-Hughto, Reisner, & Pachankis, 2015).

The need for more population specific studies on transgender health has been recognized (Institute of Medicine, 2011). Within transgender communities, there exists multiple diversities which impact the transgender person's experience of discrimination. Access to health care is influenced by gender identity; differences exist between transgender subgroups in their experience of health-care access barriers and health-care utilization (Gonzales & Henning-Smith, 2017). For example, studies have revealed that trans men have a greater tendency than trans women to delay health care due to the fear of discrimination (Cruz, 2014; Jaffee, Shires, & Stroumsa, 2016). Furthermore, researchers have identified the increased disadvantages of transgender individuals who belong to more than one marginalized community (e.g., ethnic/racial minority, low income and visually non-conforming), as these individuals experience even more prevalent discrimination and substandard care (Bradford et al., 2013; Grant et al., 2011; Jaffee et al., 2016; Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2015, 2017; Lambda Legal, 2010; Shires & Jaffee, 2015). Other research has revealed that transgender men have less access to health care than cisgender adults. Yet, these differences were not statistically significant when sociodemographic factors were controlled, which suggest an intersectional approach to practice in order to mitigate inequities (Seelman, Miller, Fawcett, & Cline, 2018). Further research is needed to explore the intersectionality of gender identity with other diversities (e.g., race/ethnicity, socioeconomic status, and age) to understand how the multiplicity of marginalized identities may impact health-care access.

This rapid review focused on transgender people's access to health care within the U.S. However, Canadian research provides convergent evidence that transgender people experience discrimination even within the single payer system in Canada. While transgender patients in Canada may not have to struggle with issues of affordability because of universal health insurance, they do encounter discriminatory treatment from health-care providers like their American counterparts. Over half (52%) of trans Ontarians have had negative experiences related to their trans identity when seeking emergency department (ED) services including being denied care (10%), receiving hurtful or insulting language (32%), or having to educate the ED provider about trans health issues "some" or "a lot" (54%) (Bauer, Scheim, Deutsch, & Massarella, 2014). Moreover, approximately half of trans Ontarians who had a family physician felt uncomfortable discussing trans health issues with their doctor (Bauer, Zong, Scheim, Hammond, & Thind, 2015). Equal availability of health care does not necessarily result in equal access. Transgender individuals in Canada remain a medically underserved population (Giblon & Bauer, 2017). The marginalization of trans people and the lack of cultural competence among health-care providers is pervasive across health systems. Future research should include a systematic review of international studies which explore the prevalence of health-care discrimination experienced by transgender people in other countries.

A consequence of informational erasure is the lack of training for health-care providers on trans health issues. Health-care providers have begun to recognize their own knowledge deficits and skills in treating transgender patients. They have also identified the structural barriers within their health-care systems which hinder the provision of medically and culturally competent care (Lurie, 2005; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). Additional research is needed to gain a contextual understanding of providers' perspectives regarding their training needs and the systemic barriers they experience. This information can be used to address knowledge deficits and create policy changes at the mezzo and macro level.

Limitations

While these studies were instrumental in elucidating the prevalence of discrimination and health related behaviors experienced by sexual and gender minority communities, there were some limitations to this research which should be highlighted. First, all the studies were descriptive in nature and utilized a cross sectional survey design; they measured exposure or conditions at the same point in time which did not allow for causal inference. Second, because sexual and gender minorities are marginalized populations which are difficult to access, all the studies used a convenience or snowball sampling method. These non-probability samples are not likely to have been representative of the diversities within the LGBT population. For example, most of the research participants were non-Hispanic white people. Third, all the studies used online surveys as a data collection method, which meant that most of the participants had internet access. Online surveys can be effective in accessing populations which are difficult to reach because of their fear of stigma and discrimination. However, one drawback is that the researchers were less likely to have accessed the most marginalized segments of the population and thus were under-reporting the social determinants of health and illness (Wright, 2005). In addition, although state specific samples were helpful to highlight the salient disadvantages experienced by sexual and gender minority populations compared to the general population, the non-probability sampling method meant that the results of the study may not be generalizable to sexual and gender minority populations in other states. The acceptance of diversity is geopolitical in the U.S., with certain states being more progressive than others in passing legislation to protect the rights of LGBT members. Lastly, the inclusion criteria for the transgender subgroup varied between studies. Some studies limited their focus to individuals who lived as the gender opposite to the one they were assigned to at birth while others included participants who were gender non-conforming (individuals whose behavior and appearance do not conform to societal expectations for a given gender). Although this difference highlights the diversity which exists with the transgender subgroup, it also limits the generalizability of the findings to other transgender or gender non-conforming populations.

Implications for social work practice

Health-care providers' attitudes about sexual orientation, gender identity, and gender expression affect the way that they relate to LGBT patients. Whether intended or not, health-care providers can display homophobic, heterosexist, transphobic, and cisgenderist attitudes and behaviors which mirror societal values. These biases limit their ability to create a therapeutic alliance with LGBT patients and create a structural barrier to accessing quality care. Researchers and practitioners have underscored the need to develop cultural competency and capacity building in serving LGBT clients in general (Adams, 2016; Hillman, 2016; Moone, Croghan, & Olson, 2016; National Resource Center on LBGT Aging, 2012; Van Den Bergh & Crisp, 2004; Wheeler & Dodd, 2011; Wilkerson, Rybicki, Barber, & Smolenski, 2011; Zuzelo, 2014) and transgender individuals in particular (Ansara, 2015; Hyderi, Angel, Madison, Perry, & Hagshenas, 2016; Marshall, Pickle, & Lawlis, 2017; Porter et al., 2016). To affirm and support the LGBT community, social workers must first examine their own conscious and unconscious biases and address their knowledge deficits related to the needs of sexual and gender minority populations. As advocates advancing health equity for vulnerable and disadvantaged populations, social workers must confront the barriers to health-care access and engage in policy initiatives which have the potential to eradicate the health disparities experienced by LGBT people (Wheeler & Dodd, 2011). Social workers have an ethical responsibility to challenge social injustice and to engage in social change efforts by promoting awareness of oppression and diversity (NASW, 2017).

The NASW's Standards and Indicators for Cultural Competence in Social Work Practice (2015) also informs the discussion about practice implications with sexual and gender minority populations. Cultural competence is defined as knowledge, skills, and attitudes enabling effective service delivery to diverse populations. Social workers must develop an awareness of their own position of power and privilege vis-à-vis the client populations that they serve. Using an intersectional approach to practice, culturally competent social workers acknowledge the multiplicity of identities and how this impacts the experience of privilege and oppression. They examine "forms of oppression, discrimination, and domination through diversity components of race and ethnicity, immigration and refugee status, religion and spirituality, sexual orientation and gender identity and expression, social class, and abilities" (NASW, 2015, p. 10). They are aware of the heterogeneity within sexual and gender minority populations and are sensitive to the challenges faced by those who identify with more than one marginalized community. Culturally competent social workers can educate other health professionals and use their influence as an integral part of health-care teams. Heterosexism, heteronormativity, cisgenderism and cisnormativity occur at multiple levels and thus, a multi-pronged approach must be used in the interventions to eliminate them. The NASW standards should be applied at the micro, mezzo, and macro levels of practice and encourages social workers to recognize and challenge individual, interpersonal, and institutional oppression (NASW (National Association of Social Workers), 2015).

Conclusion

In recent years, a national discourse has been taking place in the U.S. about transgender rights—from their ability to use public restrooms to their inclusion in the military. As concepts like erasure, cisnormativity, and cisgenderism emerge in the social consciousness, health-care providers are challenged to reexamine the dominant experience of gender and to dislocate it from its place of privilege. Researchers, advocates, and allies alike are making an impassioned plea for organizations to shift their transphobic gaze by looking beyond the conventional binary categories of gender to create an inclusive environment for transgender and gender non-conforming communities. A candid self-assessment of institutional policies and practices is required to change structural inequities which contribute to transgender people's invisibility. Because accessibility is a social determinant of health, a call to action is imperative. Not only do poor health outcomes impact quality of life for trans people and their families, but they also result in long term socioeconomic consequences through increased direct, indirect, and opportunity costs. When marginalized groups are subjugated through systemic oppression, their opportunities to make a social contribution are suppressed. Thus, transgender rights are not simply about achieving equitable access for a specific group but rather, it is also about creating an unrealized gain for the rest of society.

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