Comparing experiences and perceptions of primary health care among LGBT and non-LGBT people: Key findings from Catalonia

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Abstract

This study compares the experiences and perceptions of primary health care of respondents who self-identify as Lesbian, Gay, Bisexual, and Transgender (LGBT) with those of respondents who do not. Data were collected through a closed-ended, anonymous online survey in 2018. 468 respondents completed the survey, which included sociodemographic questions, perceptions of respondents' health status, and their primary health-care experiences. Both LGBT and non-LGBT groups were analyzed, comparing differences and similarities by using univariant analysis and contingency tables. Our results indicate that the primary health-care needs of LGBT people in Catalonia include specific requirements that are not currently being addressed.

Key words: LGBT, Primary Health Care, Health System, Public Health

Acknowledgments

We would like to express our gratitude to the LGBTQ organizations based in Catalonia; without their collaboration this study would not have been possible. We also would like to thank the Public Health Care Service in Catalonia (Institut Català de la Salut, ICS) and TRANSIT (Health Care of trans people), the City Council of Barcelona (*Regidoria de Feminismes i LGTBI)*, Manresa (*Regidoria d'Igualtat i de la dona*), and the Mancomunitat Intermunicipal de la Conca d'Òdena (*Regidoria d'Igualtat*) for their involvement and support.

Leon Freude has developed his participation in this article in the context of the INCASI RESEARCH NETWORK, a European project that has received funding from the European Union's Horizon 2020 research and innovation program under the Marie Skłodowska-Curie GA No 691004. No other funding has been received to develop this project and the research.

This article reflects the authors' view and any of the mentioned organizations are not responsible for any use that may be made of the information it contains.

Introduction

Publicly funded universal health care involves the provision of health services that ensure the coverage of the health-care needs of all residents living in a specific country or region. Further, it is paramount to health outcomes as it is the main source of health services in many welfare states (Esping-Andersen, 2013).
According to the World Health Organization, public health care should address barriers of access to health care and social disparities in health. In addition, publicly funded universal health care is meant to organize health services around people's needs and expectations, integrate health in all sectors, pursue collaborative models of policy dialogue and increase stakeholder participation (World Health Organization, n.d.). However, the notion of universality becomes problematic in the case of sexual orientation and gender-minoritized populations such as Lesbian, Gay, Bisexual, and Transgender (LGBT)[1] individuals. In order to achieve health equity for LGBT populations, health-care systems must be aware of their users' unique health needs (Lampalzer et al., 2018). Hankivsky and Christoffersen (2008) argue that gender identity and sexual orientation are relevant factors for health outcomes affecting healthcare experiences, vulnerability to diseases, quality of health care, and accessibility of medical resources. In addition, systematic exclusion and inequalities in access can result in lack of coverage, as in the case of LGBT populations, which can lead in turn to reduced life expectancy, lower quality of life, and a higher burden of acute and chronic illness (Author, 2018).

Previous research has attributed higher rates of chronic disease among LGBT populations to discrimination and minority stress (Hoy-Ellis, 2023; Veale, 2023; Frost, Lehavot & Meyer, 2015), in addition to avoidance of health-care providers and irregular access to health-care services (Ramsey et al., 2022; Thorpe et al., 2022; Martos et al., 2019; Baker & Hughes, 2016; Author, 2018; Smart & Wegner, 2000). Concerning the specific needs of LGBT populations, available data indicate that there is a higher prevalence of sexually transmitted diseases, higher rates of depression and suicide, as well as higher or specific substance use among these populations (Wilchek-Aviad & Oren, 2022; Jaspal, Lopes & Breakwell, 2022; Elliott et al., 2015; Flentje et al., 2015; Jackson et al, 2006). Research also suggests lack of knowledge, comfort or cultural competence among health-care providers attending to the unique health issues facing LGBT populations (Burcheri et al., 2023; Bishop et al., 2022a, 2022b; Andermann, 2016; Bradford et al. 2013; Makadon, 2011).

Universal healthcare was introduced in the Spanish Welfare state in the late 1980s (Lobo, 2020; Vilar Rodríguez & Pons Pons, 2018). Currently, in the highly decentralized and diverse provision of health-care services, which depends on the autonomous communities (Gallego Calderón et al., 2013; Gil & García, 2016), the Catalan model is praised in terms of innovation (Alfama et al., 2011), efficiency and positive patients' evaluation (Rocha et al., 2011). It offers public health care to all residents and is characterized by the separation of funding and provision, as well as the diversity of providers (Esteve-Matalí et al., 2022; Ballart & Galais, 2019). The Catalan law against LGTB discrimination explicitly requires the suppression of any kind of barriers experienced by LGBT people

[1] We use the acronym LGBT as it is used in the Catalan law against homophobia 11/2014, which was the result of social pressure by emancipatory social movements. We omit the "I" in LGBTI as neither our data nor our discussion include any references to intersexuals. The use of LGBT is justified, on the one hand, by the legal framework for sexual diversity in Catalonia (which includes public primary health care) and, on the other hand, based on the issues that emancipatory social movements are struggling for and the terms they use to refer to them.

in the Catalan Health Care System and the use of LGBT inclusion policies (García et al., 2020).

The main objective of this study was to identify existing differences between LGBT and non-LGBT individuals' perceptions of primary health-care needs in the public Catalan Primary Health-Care System. To do this, we examined whether or not LGBT people have equal access to the primary health-care system and if they consider themselves to be treated respectfully. We also analyzed their perceived health status and their specific health needs. This has important implications for feminist research in Catalonia, which is eager to adopt a perspective including issues of sexual orientation and gender identity (Romero Bachiller & Montenegro, 2018; Biglia & Vergés, 2016; Cruells & Coll Planas, 2013). It is also important to note that health research on sexual and gender diversity generally focuses on sexual health (Sönmez et al., 2022; Agustí et al., 2020; Di Feliciantonio, 2020; Jacques-Aviñó et al, 2019; Leyva-Moral et al, 2018; Folch, 2009) instead of adopting a wider focus or, when it does so, the samples used are usually small, as in Martí-Pastor et al. (2018) and Pérez et al. (2015). This article offers innovative insights into these issues, being one of the first quantitative studies of LGBT people in the Catalan Health-Care System.

This research contributes to existing research as it applies an existing measuring instrument (authors, 2018) to the Catalan context. It also amplifies research: in Nova Scotia the instrument has been applied only to LGBT individuals, while in this research we compare non-LGBT respondents with LGBT respondents.

Methods

Respondents and data collection

Data were collected from a non-random sample of both LGBT individuals and the general non-LGBT population in Catalonia, Spain, in 2018. Inclusion criteria were: self-identifying as LGBT or self-identifying as non-LGBT; being able to understand Spanish or Catalan; having lived in Catalonia for more than one year; being 18 years of age or older; and being a user of the Catalan Primary Health-Care System.

468 participants completed an anonymous online survey. Of these, 283 participants self-identified as members of the LGBT community, and 185 participants self-identified as non-LGBT (Annex, Table 1). The survey was distributed through LGBT associations based in Catalonia by means of an email explaining the aims of the study, and it guaranteed anonymity and confidentiality to all participants. The participants were also prompted to forward the questionnaire to other contacts. In addition, three university research associates promoted the survey online and offline collaboratively with the research team in order to reach a broader audience, and it was distributed using the snowball technique.

Procedure

We developed our online survey out of a prior survey used for a similar study in Nova Scotia (Canada) (authors, 2021), which was conveniently modified for use with the Catalan Primary Health-Care System (ICS). We adjusted the questionnaire based on the suggestions of professionals. We posted the final web-based survey online using Qualtrics software following approval by the Universitat de Barcelona BioEthics Committee. The survey stayed open for a total of six months.

Measures

The online survey used in this research was developed by the authors (2018) and several colleagues for a study of access to Primary Health Care in Nova Scotia (Canada) and then adapted for the Catalan Primary Health-Care System (ICS). The original online survey was developed collaboratively between the research team and the community advisory board following both the completion of a scoping review on the key factors affecting LGBT health, as well as community consultations in urban and rural Nova Scotia, Canada, with community stakeholders (see authors, 2018). The current survey consisted of closed-ended questions mainly related to sociodemographic factors, self-perceived health status as well as scales of importance of different health services, and open-ended questions to further explore the health-care experiences of the participants. To identify specific health-care needs of the LGBT community, respondents were asked to indicate the importance for their health of several aspects on a scale ranging from very important and important, down to not important and not at all important. These aspects included: (1) assessment of sexual and reproduction health; (2) information on sexuality; (3) assessment of food and healthy-eating habits; (4) psychological assessment on depression, anxiety and stress; (5) assessment on sexually transmitted diseases and supply of safer sex materials; (6) cardiac illnesses, (7) psychological assessment on IPV; (8) psychological assessment on sexual abuse; (9) psychological assessment on mental or physical harassment, (10) measures to reduce risk of infection; (11) psychological assessment on self-injury and suicide, (12) psychological assessment on low personal or bodily self-esteem; (13) psychological assessment in case of substance abuse; (14) psychological assessment on being LGBT; (15) having a service attending trans people. In addition to these items, respondents had the opportunity to include other health issues. In order to compare the evaluations provided by the two groups, LGBT and non-LGBT, we measured the relationships between their respective assessments of the importance of each item.

Respondents completed the survey electronically by selecting radio buttons, checking boxes, and typing in text, depending on the nature of the question. Table 2 shows the questions with their response categories (Annex, Table 2).

Data Analysis

We analyzed our data in search of differences and similarities between our LGBT and non-LGBT samples using univariant analysis and contingency tables. Chi-square (χ^2) was used to determine if there were any differences between the LGBT and non-LGBT samples, while Cramer's V served as an indicator for the strength of relationship, with 1 standing for a perfect relation, and zero indicating absence of relationship (López-Roldán & Fachelli, 2015; Domínguez Amorós & Simó Solsona 2003; Kotrlik & Williams, 2003). Contingency tables permit the measuring of global and local relations: chi-square (χ^2) informs about the existence of a relationship, while Cramer's V indicates the strength of the global relationship between variables. Based on Cramer's V, we also indicate the effect size according to Rea & Parker (1992) and Kotrlik & Williams (2003). When we look into the cells, adjusted standardized residuals over 1.96 imply local relationship between categories (López-Roldán & Fachelli, 2015; Domínguez Amorós & Simó Solsona 2003). Given the sample-size and our interest in comparing specifically LGBT identified and non-LGBT identified patients' opinions and perception we opted for an explorative bivariate analysis (López-Roldán & Fachelli, 2015; Domínguez Amorós &

Simó Solsona 2003). Further research with bigger samples is needed to introduce more independent variables.

The following section presents the key results of our survey, including a ranking of the different aspects considered to be important for their health by LGBT and non-LGBT participants in order to illustrate their differences in terms of health-related priorities.

Results

The key results of our survey are presented starting with the respondents' perceived health status, followed by their satisfaction with the public primary health-care system, their specific health-care needs, and the degree of coverage that the health-care system offers. The sample is a young sample (average age 29 for LGBT and 30 for non LGBT), which also illustrates that most of the interviewees are students. This has to be taken into account for the interpretation of the results. For instance, there are a number of health issues that may not feel relevant to them due to their younger age (e.g., cardiac concerns). Also, most of them are living in the province of Barcelona and were born in Catalonia. There are no statistically significant differences between LGBT and non-LGBT-samples in terms of sociodemographics. See Table 1 for the description our sample.

Perceived health

When asked about their self-assessment of their perceived health on a scale from very good to good, fair and bad, we found that both groups rated themselves as having good health (61.1% in the case of non-LGBT and 57.2% in the case of LGBT). Furthermore, 22.2% of the non-LGBT sample and 22.5% of the LGBT one perceived their health as very good, while 14.4% of the non-LGBT responses and 18.8% of the LGBT responses stated that they perceived their health as fair. Only 2.4% of the non-LGBT responses and 1.5% of the LGBT ones rated their own health as bad. No statistically significant relationship was detected in this respect.

Satisfaction with the public primary health care system

Our results indicate that both groups are preferably satisfied, rather than unsatisfied, with the professionals in the public primary health-care system. The majority of our sample said they were satisfied (49.5% of the non-LGBT sample and 47.9% of the LGBT one), somewhat satisfied (24.8% of the non-LGBT sample and 16.0% of the LGBT) and very satisfied (13.3% of the non-LGBT and 16.0% of the LGBT sample) with primary care staff. While there are no statistically significant differences between these responses, as it is shown in Table 3, LGBT participants did report being very unsatisfied with the professionals within the public primary health system (8.3%) quite more often than the non-LGBT control group (2.9%).

When asked to rate their confidence in health-care staff, both groups displayed high rates of confidence, with no statistically significant differences between them (see Table 3). Specifically, 74.1% of the non-LGBT respondents and 67.4% of the LGBT ones trust the medical staff of public primary health providers. However, it is important to acknowledge a high degree of mistrust in both groups: more than a quarter of our sample reported not trusting the staff in the public health system (32.6% of LGBT respondents and 27.5% of non-LGBT ones).

As for the LGBT-friendliness of public primary health-care centers, our data detected lack of awareness of the matter, as both groups mostly responded that they did not know

if their center could be considered LGBT-friendly (50.9% of the non-LGBT sample and 44.1% of the LGBT one). However, there were also many participants who confirmed that the health center they attended was quite LGBT-friendly (23.7% of responses in the case of the non-LGBT sample and 29.2% in the case of the LGBT sample), somewhat LGBT-friendly (10.5% in the case of the non-LGBT sample and 11.4% in the case of the LGBT one) or very LGBT-friendly (5.3% in the case of the non-LGBT 7.9% in the case of the LGBT sample). Only 7.0% of the non-LGBT sample and 7.4% of the LGBT sample considered their primary health centers not to be LGBT-friendly, whereas only 2.6% of the non-LGBT sample considered them to be not at all LGBT-friendly. Both groups perceived the LGBT-friendliness similarly, with the only statistically relevant difference found locally in the "very LGBT-unfriendly" response (Table 3). This suggests that non-LGBT respondents have a general perception of the staff at public primary health centers as less LGBT-friendly than they are perceived by the LGBT population.

As for the perception of health-care providers' concern about the specific health needs of the LGBT community, both groups are similar in that they do not present any statistically significant differences (Table 3). Almost half of the sample thought that health-care staff are aware of some but not all of the specific needs of LGBT populations (41.7% of the non-LGBT sample and 48.0% of the LGBT one). More than one quarter of the sample did not know if health-care staff tended to the specific needs of LGBT populations (25.9% of the non-LGBT sample and 26.2% of the LGBT one) and nearly one quarter of the interviewees considered that the specific needs of the LGBT community were not attended to by health-care providers (with 21.3% of the non-LGBT sample and 17.8% of the LGBT sample suggesting that the health-care staff are not aware of the specific needs of LGBT populations). In addition, only 11.1% of the non-LGBT respondents and 7.9% of the LGBT ones thought that their health-care staff are fully aware of the unique health-care needs of LGBT patient populations.

Coming Out

A special concern of LGBT patients and health-care staff is the issue of "coming out" (or making their non-heterosexual identity explicit). When we asked the LGBT respondents if they had shared their sexual orientation with their medical staff and the non-LGBT control group if they *would* share it with them, our results showed that 62.3% of the non-LGBT respondents would share their sexual orientation with medical staff, whereas only 37.7% of the LGBT patient sample had shared such information with health-care staff (Annex, Table 4). This finding indicates a moderate difference (Kotrlik & Williams, 2003) in perceptions of homophobia between non-LGBT and LGBT populations. Specifically, issues of cultural safety and sensitivity in health-care settings are paramount if health-care providers want to better understand the unique health-care needs of their LGBT patients.

When asked about how they felt about sharing their sexual orientation with health care staff, most non-LGBT respondents answered that they felt comfortable (40.6% of non-LGBT and 36.4% of LGBT) or very comfortable (8.9% of non-LGBT and 26.0% of the LGBT) (Annex, Table 5). Furthermore, 22.8% of the non-LGBT sample and 24.7% of the LGBT one responded that they would feel just a bit comfortable telling the medical staff about their sexual orientation. None of the non-LGBT respondents felt a bit uncomfortable, while 13.0% of the LGBT respondents said that they felt so. Finally, 27.7% of the non-LGBT sample and none of the LGBT respondents felt very

uncomfortable about sharing their sexual orientation with the medical staff. The strength of the relationship can be described as "relatively strong" in terms of Kotrlik & Williams (2003). These data further indicate the need to address issues of disclosure of one's sexual orientation to health-care providers generally, and perceptions of homophobia and transphobia in health-care settings specifically.

Important aspects of health

Concerning the importance of different aspects of health and health-care services, the results show differences in the interviewees rating of the importance of cardiac illness prevention (Cramer's V, 0.214**, Table 6), information on sexuality (Cramer's V, 0.250**, Table 6), assessment of sexual and reproductive health (Phi, 0.275**, Table 6), assessment regarding food and healthy eating habits (Cramer's V, 0.177*, Table 6) and psychological assessment in case of substance abuse (alcohol, other drugs) (Cramer's V, 0.167*, Table 6). According to Kotrlik & Williams (2003), the differences in cardiac illness prevention and information on sexuality are of moderate strength, while the differences on assessment regarding food and healthy eating habits as well as psychological assessment in case of substance abuse (alcohol, other drugs) are weak.

With regard to cardiac illness prevention, our key results found that the main differences between LGBT and non-LGBT respondents can be found in the response categories "important" and "very important" (Annex, Table 7). While only 24.2% of non-LGBT participants considered cardiac illness prevention to be important, this number rises up to 40.2% in the case of LGBT subjects (Annex, Table 7). On the other hand, 55.7% of non-LGBT consider cardiac illness prevention to be very important, while just 35.1% of LGBT do.

In the case of assessment regarding food and healthy eating habits, the existing differences between LGBT and non-LGBTs are also a question of detail (Annex, Table 8). While non-LGBT participants suggest that food and healthy eating habits are important for their health (30.2%), non-LGBTs think so to a greater degree (44.4%). In addition, 59.7% of non-LGBT respondents say that assessment regarding food and healthy eating habits is very important for their health, while among LGBT people this is just 42.5%.

Regarding the importance of having information on sexuality, the difference is notable: non-LGBT participants report being unsure about the importance of information on sexuality in 10.1% of the cases, while only 1.9% of LGTB participants answered so (Annex, Table 9). Also, we see that non-LGTB participants consider information on sexuality important for their health less often (22.1%) than LGBT participants (41.7%).

As for psychological assessment in the case of substance abuse (alcohol, drugs), non-LGBT state less often that this issue is not important for their health (1.3%, vs. 6.6% of the LGBT sample [see Annex, Table 10]). In addition, non-LGBT participants consider psychological assessment in case of substance abuse (alcohol, drugs) to be very important overproportionally, with 47.0% against only 35.9% of LGBT respondents holding this position.

With respect to the importance of assessment of sexual and reproduction health, we found substantial and quite nuanced differences (Annex, Table 11). We must note here that non-LGBT participants' answers suggest that sexual and reproductive health is not related with their health (5.4%), whereas, for LGBT participants, it is 13.9%. That could mean that for non LGBT respondents, assessment of sexual and reproduction health is not even

a question of primary health care. On the other hand, we see another significant difference: only 20.1% of the individuals who self-identified as non-LGBT considered assessment of sexual and reproductive health important, while 30.9% of LGBTs thought it relevant for their health. Also, 61.1% of non-LGBT participants considered assessment of sexual and reproductive health very important, while only 33.6% of the LGBT participants did.

These nuanced differences suggest the importance of comparing both groups' rankings of key issues related to health. Specifically, while the assessment of sexual and reproductive health is of prime importance (61.2%) for the non-LGBT sample, it is the least important item for the LGBT sample (33.0% "very important" answers). Counseling on food and healthy eating habits is the fourth most important item for the non-LGBT sample (59.7% "very important" responses), but it only occupies the eighth position for non-LGBT people (42.5% of whom considered it "very important"). Cardiac illnesses also matter more to people in the non-LGBT sample (7th position, with 55.7% marking the "very important" box), while the LGBT sample places it in the 14th position (35.1%). Instead, the LGBT sample rates the assessment of sexual transmitted diseases as very important (54.8%), followed by information on sexuality (51.0%) and psychological assessment on depression, anxiety and stress (42.5%).

Once we add up the "important" and "very important" responses, small changes in the rankings can be seen. For example, counseling on food and healthy eating habits occupies the first position for the non-LGBT participants (89.9% "important" and "very important" answers), while it only occupies the second position (86.9% "important" and "very important") in the ranking of the LGBT participants, who prioritize information on sexuality (92.7% "important" and "very important"). The third priority for non-LGBT respondents is advice on healthy aging (82.5% "important" and "very important" responses), while this item is in the ninth position in LGBT people's ranking of priorities (65.5% "important" and "very important" answers). LGBT responses, instead, consider information on sexuality as "very important" or "important" (97.2%), followed by assessment on food and healthy eating habits (89.9%), and assessment on sexually transmitted diseases and provision of safer sex materials (82.6%).

In our results, we detected some differences in weight and importance of key health issues. For example, we can see that the assessment of sexual and reproductive health appears to be a less relevant topic for LGBT respondents, the same as cardiac illnesses and the assessment of food and healthy eating habits. Instead, sexuality and the assessment of sexually transmitted diseases and provision of safer sex materials are regarded as much more important health-care issues by our LGBT respondents.

Specific needs

As it was mentioned previously, all participants identifying as LGBT were invited to offer qualitative information about the specific health-care needs of the LGBT population in the survey. Fifty-eight respondents completed the open-ended text box with very brief comments. These responses were grouped into categories to get a better understanding of these closed-ended responses. After reviewing the data, two major concerns were revealed: sexually transmitted infections (STIs), and psychological counselling. In addition, participants mentioned the need for health-care providers to have additional training in order to be able to give advice on sexuality, reproduction and general treatment. Finally, there were also several comments regarding gynecologists, transgender assessments and pediatric care. This is important information that

complements the items specified above and increases the range of LGTB people's specific health-care needs.

Concerning STIs, our respondents suggested the need to offer specific services and information developed for and by LGBT populations. Also, they pointed out the need, in both urban and rural settings, for walk-in STI clinics where access to STI self-testing and pre-exposure prophylaxis (PrEP) is provided as part of the primary health-care assistance.

Mental health care and psychological treatment in primary health care was also seen as an important need by LGBT respondents. Specifically, respondents identified the need for psychological treatment to take into account sexual orientation and gender diversity, both in the context of individual psychotherapy as well as in group therapy.

Moreover, it is noteworthy that the prevailing atmosphere or culture at the health-care center can be a barrier for users to access the needed health care. For example, while respondents do not want to be directly assumed as heterosexuals by the medical staff, they do want their sexual behavior to be considered as a core issue either. In fact, many respondents noted that they would prefer not to be forced to fit into strict labels or categories. Finally, access to primary health-care services that include family planning was seen as a priority health-care issue. Specifically, respondents are seeking access to gynecologists in general, and to gynecologists trained on sexual diversity, specifically in relation to lesbians. Also, there is an expressed need to improve the assessment of transgender people and to have access to gender-affirming hormones and gender-affirming surgical procedures.

Health Care Coverage

All respondents were asked about their use of private and alternative medicine in order to identify the coverage of the public health-care system. Our results indicate that the majority of the participants do not use alternative medicine (87.7% in the case of the LGBT and 81.6% in the case of the non-LGBT).

Our data also suggest that one of the reasons for this may be that both groups consider their health to be good, or very good. We also showed that, in general, participants trusted their health-care staff, considered them to be LGBT-friendly, and were overall satisfied with the health care they supplied.

Discussion

This paper explores the experiences and perceptions of primary health care among a sample of LGBT and non-LGBT adults in Catalonia, thus addressing an issue raised by public debate, social pressure, and legislation (García et al., 2020). According to the results obtained, the Catalan public primary health-care system is not free of barriers and other issues related to sexual orientation and gender identity, a finding which is also supported by previous research (see, for example, Lampalzer et al., 2018; Frost, Lehavot & Meyer, 2015; Fredriksen-Goldsen et al. 2013).

Perceived health

Previous studies on health indicate that people's perceived health is an important indicator of their actual health and often correlates with it (Castro-Vázquez, 2007; Lee & Shinkai, 2003; Leinonen, Heikkinen & Jylhä, 2002). According to previous research (Baker & Hughes, 2016; Smart & Wegner, 2000), LGBT populations evaluate their health as being worse than non-LGBT populations. Our results cannot confirm these findings (for the statistical relation, see Table 2) and rather align with the findings of Seo et al. (2015)

stating that there are no important differences in perceived health. Comparing our results with the findings from the Nova Scotia study (authors, 2018), we see that Catalan LGBT respondents rank their health status similarly to the Canadians. In this sense, taking into account that our sample is mainly composed by young adults we can assume that this is due to the fact that younger people have a good perceived health.

Satisfaction with the public primary health care system

In general terms, we did not observe any significant differences concerning satisfaction with health-care professionals, trust in health-care professionals, LGBT-friendliness of primary health care and attention to the specific needs of LGBT people. This may be explained by a selection bias in the sample, as heterosexuals responding a questionnaire on LGBT health might be overproportionally in favor of LGBT rights. On the other hand, it might show that, in our sample, there was no distinctive perception of the satisfaction with health-care professionals, trust in health-care professionals, LGBT-friendliness of primary health care and attention to specific needs of LGBT people.

Overall, our results reveal a high degree of satisfaction with the public health-care system and its professionals. This is surprising given the harsh budget cuts in health care in the context of the austerity programs and the financial crisis in Spain (Biglia & Olivella-Quintana, 2014). This high degree of satisfaction challenges the existing literature, where previous research (see for example, Rodó Zaráte, 2022; Andermann, 2016; Bradford et al., 2013; Makadon, 2011) suggested that LGBT populations perceive their experience of health care as a negative one. Broadly speaking, our results indicate that there are no significant differences between LGBT and non-LGTB people concerning their general satisfaction with and confidence in the health-care staff, neither there are any statistically significant differences regarding the LGBT-friendliness of health care providers or their tending to LGBT population's specific health-care needs.

However, there are some nuanced differences. Specifically, we found that LGBT respondents are overrepresented amongst the very few who declare to be very unsatisfied with the medical staff. According to Ramsey et al. (2022), dissatisfaction with medical staff from the perspective of LGBT patients might stem from a refusal to treat them, harassment and violence, or simply a lack of knowledge of LGBT-specific health concerns and needs. Other explanations for dissatisfaction with primary health-care staff are experiences of anti-LGBT discrimination, heteronormativity, or the presumption of heterosexuality (Biglia & Olivella-Quintana, 2014).

Regarding the LGBT-friendliness of primary health-care centers, we must point out, first of all, that the concept does not appear to be very clear to the respondents, as most of them answer that they do not know. The only statistically significant difference – non-LGBT people stating that primary health care is not at all LGBT-friendly – should be explained similarly to above: the heterosexual respondents participating in a questionnaire on LGBT inclusion in the health-care system might be especially sensitive to the issue, seeing themselves as allies, and exaggerating the system's possible insensitivity. However, the comments by the respondents that we presented above suggest that there are some serious problems regarding LGBT-friendliness, although our quantitative results do not strongly support this interpretation. In this sense, our data also reveal that the public primary health-care system needs to develop further competencies to address the specific health-care needs of LGBT patient populations.

In terms of trust, LGBT and heterosexual respondents do not differ in their responses, but the percentage of distrust is worrying, as it constitutes more than a quarter of the overall sample. Health-care providers and professionals should make efforts to ensure trust and adopt a more patient-centered approach.

Although the role of health-care providers in addressing the unique health-care needs of LGBT populations has been evaluated somewhat positively our present study, there are a number of persistent issues that require urgent attention. The interactions between health-care providers and LGBT patient populations are critical in order to ensure timely and appropriate health care. As we noted in an earlier research, many health-care providers do not feel knowledgeable, comfortable, or competent when it comes to providing care to LGBT patients (García et al., 2020). As such, there is a pressing need to ensure health-care providers are receiving the required training, both while in their programs of study as well as upon graduation, to ensure the health care they offer is in keeping with national and international standards (Rodó-Zaráte, 2022; Langarita, Mas Grau & Albertín Carbó, 2022; Coleman 2009; Coleman & al., 2012a).
Compared to the results from the Nova Scotia study (authors, 2018), LGBT respondents show similar satisfaction with the staff in primary health care centres. Also, there is a high degree of uncertainty regarding the LGBT-friendliness of the providers.

Coming Out

The reluctance to "come out" as a LGBT person in front of health-care providers has important implications for addressing the health needs of LGBT patient populations, including issues such as foregone health care, whereby LGBT patients avoid health-care systems even when there is an urgent health-care need (see, for example, de Vries, 2015; Brennan-Ing et al. 2014; Fredriksen-Goldsen et al. 2014; Hatzenbuehler et al., 2013). In fact, more than one out of ten participants felt uncomfortable or would feel uncomfortable coming out to a health-care provider. Assuming that sexual orientation and gender identity often represent important information for diagnostic purposes, we stress the urgent need for this issue to be addressed through additional training and information for health-care providers. In addition, the reluctance of the non-LGBT respondent group to hypothetically come out shown in our results (Annex Table 4) also has can have important health-care implications, particularly given that sexual orientation and sexual practices vary across the life course and may manifest a degree of anticipated homophobia.

To foster a health-care climate that makes *coming out* to health care providers safe and affirming is critical. This is a significant challenge for those LGBT patients who are very unsatisfied with primary-health providers. García et al. (2020) point out the training needs of primary health-care staff in Catalonia, and our results support their findings. A different option, although this one calls into question the paradigm of universality of health care, is the setting up of LGBT-specific clinics (García et al., 2020; Martos, 2019).

Specific needs

Generally speaking, all the items ranked high in terms of their importance for the interviewees' health. The overall differences between non-LGBT and LGBT respondents were small. This is surprising if we take into account that earlier research has illustrated important health differences which should lead to an increased importance of several issues for LGBT patients. Here, two main interpretations are possible: firstly, LGBT

respondents are underestimating their actual vulnerability, or, secondly, non-LGBT people are overestimating their vulnerability. If this were the case, there should be more information on the specific health issues facing LGBT people. On the other hand, this may suggest the need for a comprehensive and integral public primary health system in which many different kinds of services are seen as important for all, regardless of one's sexual orientation or gender identity. Other important measures should include the territorial implementation of health-care policies beyond the city of Barcelona, and an easily accessible service, as well as LGBT inclusive and easily accessible treatment of STIs. In this sense, our qualitative data indicate the need to further reduce barriers of access to primary health care among LGBT populations. Primary health care can play an important role in sexual and mental health education throughout the life course as well as in STI prevention. However, to be fully effective, health education must adopt a non-heteronormative point of view on sexuality and gender identity.

As indicated by our data, differences between non-LGBT and LGBT respondents exist in health-care issues related to reproduction and contraception, which are seen as significantly less important by LGBT respondents. This contrasts with previous research (Leibetseder & Griffin, 2020; Biglia & Olivella-Quintana, 2014), as well as with the open-ended comments of our respondents regarding specific needs, which showed that reproductive care is an issue for them. It also contradicts the results of the Nova Scotia study (authors, 2018), where reproduction and contraception figure as one of the most important aspects. This might be due to the growing awareness and social acceptance of same-sex parenting among LGBT populations., and in society more broadly, as well as to the existing diversity inside the LGBT community. Also, it could be related to respondents young age, as father-/motherhood in Spain trend towards having children later in life.

Our data from the Catalan context are consistent with previous research from other countries, which also point to the issues of sexuality and assessment on sexually transmitted infections (STIs) as key health-care concerns among LGBT populations (Makadon, 2011). In this line it confirms the findings from the Nova Scotia study (authors, 2018). Previous research also confirms that access to primary health care among LGBT populations improves when an inclusive stance on sexuality and gender identity is taken (Ramsey, 2022; Sönmez, 2022).

It is interesting to note that, although research in different times and places has found that some LGBT populations are more affected by cardiac illnesses, psychologic problems (Elliott et al., 2015; Jackson et al, 2006), STIs (Sönmez et al., 2022; Agustí et al., 2020; Di Feliciantonio, 2020), and drug consumption issues (Agnew et al., 2022; Sönmez et al., 2022; Ramsey, 2022; Elliott et al., 2015; Folch et al., 2009; Jackson et al, 2006), LGBT people do not consider their treatment in primary health care more important than non-LGBT people. This makes sense in a context of important amplifications of LGBT rights in Catalonia and Spain, as well as important social support for the social inclusion of sexual and gender diversity (Author, 2021; Sadurní & Pujol, 2015). Ramsey (2022) and Martos (2022) suggest community-based LGBT-specific clinics and providers are a way to attend to the health needs of LGBT people appropriately. These third-sector services, often run by LGBT organizations, are already available in Barcelona, especially for STI testing, HIV prevention, sex education and family planning. As mentioned previously, due to the young age of our respondents they might not be affected by cardiac illness yet, and therefore it is not considered an important issue for them. Finally, it is noteworthy to

recall that some of the issues addressed in the study are more likely to be of concern for certain groups (e.g., women may be more concerned about reproductive health; MSM may be more concerned about HIV; gay and bisexual men might be more concerned about STI). In this sense future research in Catalonia must take into consideration that some aspects are likely to be of concern only for certain subgroups.

Conclusion

This research offered a comparison of the perceived health status and user's experience of a sample of LGBT and non-LGBT populations as users of the Catalan public primary health system. Importantly, this is one of the few studies specifically focused on the health-care needs of LGBT populations in Catalonia, offering new data and new insights into the provision of health care for these populations. It also replicates a study from Nova Scotia, Canada, (authors, 2018) adding the comparison between LGBT and non-LGBT populations.

As our findings showed, the health care and treatment received by LGBT populations in the public primary health-care services are relatively good, although certain challenges persist. These challenges are, in part, related to the issues of sharing one's gender identity or sexual orientation with health-care providers, the level of satisfaction with health-care staff, the perceptions of LGBT-friendliness in health-care settings, and certain gaps in the system's attention to the specific health-care needs of LGBT populations. Our findings underscore the need for additional training opportunities for health-care providers to ensure that health-care personnel and systems, both aimed at keeping populations well, do not contribute to poor health outcomes among LGBT populations throughout their life course.

Implications for Research

In terms of its research implications, our study does not align with the existing literature regarding perceived health. In this respect, no differences were found between LGBT and non-LGBT populations. Other findings in our study were properly in line with the existing research, including the dissatisfaction of LGBT populations in relation to their specific health needs, and their concerns about coming out to health care providers. This suggests that, in order to design evidence-based health-care policies, more research on the particular health needs of Catalan LGBT populations is needed.

One of the most important limitations of this paper, and most of the research on LGBT health in general, is sample size. Here, we must note that representative sampling is expensive. There is an urgent need to increase funding for research on LGBT health in general and access to health care more specifically, which is in line with Catalan legislation that presently requires research to promote LGBT equality (García et al., 2020). In terms of the academic debate, our results raise the following questions due to its contrast with existing results: firstly, is there any difference between LGBT and non-LGBT people regarding their perceived health? Secondly, are LGBT people less satisfied with primary health care? Thirdly, are LGBT people less interested in assessment on reproduction and contraception?

Policies

In terms of health-care policies, there are two main implications of our results: on the one hand, our quantitative data seemed to show that LGBT people consider several aspects of primary health care in a way similar to that of non-LGBT people. On the other hand, we

noticed some differences in their ranking of priorities, differences which became clearer when the qualitative information we also gathered was taken into account.

Our first finding – the fact that LGBT people consider several aspects of primary health care as important for their health as non-LGBT people do – makes it clear that more information is needed. While objective data shows that parts of the LGBT populations are overproportionally affected by sexually transmitted diseases, depression and suicide, as well as substance use (Elliott et al., 2015; Flentje et al., 2015; Jackson et al, 2006), LGBT people as a whole do not seem to be aware of it. Therefore, public administrations and third-sector organizations need to make an effort to inform LGBT people of their specific health-care risks.

As for our second finding, some of the particular differences and needs we detected in our study carry with them more specific policy implications. Besides this, it is always important to incorporate the dimension of sexual diversity in the evaluation of health-care policies. Specifically, LGBT interviewees demand more information on sexuality. This can involve leaflets at primary health-care centers, specific assessments, or proactive training sessions.

The ranking of priorities that came up in our research indicates that sexual and reproductive health is important for parts of the LGBT population. The public health system must ensure the same access to reproduction services for LGBT and non-LGBT populations. Earlier research shows that Catalonia still has important barriers to health-care access in this respect (authors, forthcoming; Leibetseder & Griffin, 2020; Biglia & Olivella-Quintana, 2014), although, legally, equal access should be granted (García et al., 2020).

As psychological assessment on depression, anxiety and stress ranks very high in LGBT's priorities, health policies taking into account the needs of LGBT people ought to offer psychological attention at the level of primary health care. For now, psychological assistance is precariously covered by the public primary health-care system, with long waiting lists (Leyva-Moral et al., 2022); this is why those who can afford it end up paying for private therapy. On the other hand, psychology still has a problem of hetero- and cis-normativity. This is why hetero- and cisnormative biases should be addressed at trainings.

LGBT people, especially younger individuals, are overproportionally affected by eating disorders (Parker & Harriger, 2020). However, they do not consider assessment on food and healthy eating habits more important than non-LGBT people do, even though they rank it as a very important issue for their health. Public health needs to address eating disorders, as well as their prevention, in order to promote a healthy lifestyle. Therapy for eating disorders and support for the relatives of the affected people, as well as information campaigns, should be fostered by the Catalan government health-care policies and in close connection with the public primary health-care system.

As for assessment on sexually transmitted diseases and supply of safer sex materials, LGBT people also ranked this issue very high in their agenda. While there exist a few programs – such as testing facilities or access to PrEP (pre-exposure prophylaxis) (Laguno et al., 2022) –, these are both too limited and sometimes too focused. In our questionnaire, trans men and lesbians asked for more specific information and strategies regarding safer sex. In the public debate, activists denounce long waiting lists to get access to PrEP or more recently, to the vaccine against monkey pox. In addition, they denounce uninformed medical staff concerning STI at the primary health level. In this

sense, there is a need for more resources, e.g., to grant access to PrEP; it is also necessary to broaden their scope and include lesbians and trans men in STI prevention policies. Finally, health-care staff needs to be trained in STI related issues.

The issue of "coming out" remains a challenge for many LGBT persons. Additional training on sexual diversity and tolerance towards sexual diversity could be developed in the form of information-sharing sessions and roundtable discussions on sexual diversity, etc. (Coll Planas, 2018).

These efforts to create LGBT-friendly health-care services require training of the medical and administrative staff in the primary health-care system. It is necessary to introduce training on diversity and awareness in their basic formation, as well as offering continuous training, as it is common in other contexts (Oliveira Ferreira & Nascimento, 2022). This implies policies which include the training about sexual diversity in vocational training courses and university degrees, as well as in the catalogue of continuous training workshops offered by the Catalan Health Care Service.

Limitations and challenges

The limitations of this research include its small sample size, the young age of the respondents, the lack of generalizability, and absence of random sampling. For future LGBT health research in Catalonia, it will be important to create larger samples that permit separate analysis by sexual orientation and gender identity (lesbian, gay, bisexual men, bisexual women, transgender, heterosexual separately). Larger, more representative surveys would also permit the introduction of an intersectional approach (Galaz et al., 2021; McCall, 2005; Crenshaw, 1989) taking into account differences based on sexual or gender identity related to sex and gender (Thorpe et al., 2022; Biglia & Vergés, 2016; Biglia & Olivella-Quintana, 2014), urban or rural residents (Agustí et al., 2020; García et al., 2020), social class (Agustí et al., 2020), migration (Gerena, 2022), minority ethnicity or religion (Thorpe et al., 2022; Coll-Planas et al., 2021a; Coll-Planas et al., 2021b; Martos, 2019) and age. In this sense, it must be admitted that the LGBT community is not a homogenous category and that the health issues and specific needs of lesbian, gay, bisexual and trans people are different, and also that they intersect with other categories such as race, age, (dis)ability, class, etc. In this article, we focused on the comparison between LGBT and non-LGBT populations, as Catalan law and social movements treat them as a political subject. In future studies with larger samples, lesbians, gays, bisexuals and transsexuals should be analyzed separately. Also, other categories such as race, age, (dis)ability and class need to be introduced in the analysis.

Future studies need to make an effort to include the whole range of ages. We also must admit that our sample consists of people who have chosen to use the healthcare system at some point. Those subjects who do not access public primary health care (because they have alternatives, mostly private or community based or because they do not use health care) are not included in our sample. As mentioned previously our study focuses on the public health care system, therefore other alternatives are not included in our sample.

Finally, it is important to acknowledge that quantitative studies limit the complexity of lived experiences and force them into a predetermined structure (Biglia & Vergés, 2016). Future research should include mixed-method models in order to give lived experiences a voice (Biglia & Bonet, 2009).

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Annex

Table 1. Sociodemographic characteristics of the sample		
	LGBT	Non-LGBT (Straight)
	293	185
Origin		
- **Catalonia**	80.7%	86.0%
- **Outside Catalonia**	19.3%	14.0%
Education		
- **Master or PhD**	13.9%	9.9%
- **Undergraduate degree**	35.7%	33.3%
- **Secondary education**	38.2%	43.3%
- **Primary education**	1.1%	1.2%
- **Without primary education**	0.7%	0.6%
- **Others**	11.7%	10.4%
Occupation		
- **Wage earner**	30.4%	34.1%
- **Self-occupied**	5.0%	2.4%
- **Student**	53.6%	54.1%
- **Unemployed**	4.6%	3.5%
- **Pensioner**	0.7%	1.2%
- **Other**	5.7%	4.7%
Age		
- **Mean**	29	30
- **Standard Deviation**	11	12
Sex		
- **Women**	55.3%	69.7%
- **Men**	39.6%	22.2%
- **Other**	5.1%	8.1%
Provinces		
- **Barcelona**	92.1	94.1%
- **Girona**	5.7%	2.4%
- **Lleida**	0.4%	1.2%
- **Tarragona**	1.8%	2.4%

Table 2. List of variables

Variables' codes and questions	Responses and codes
V1. What is your degree of satisfaction with health professionals in primary care centers?	Very satisfied (1) Satisfied (2) A bit satisfied (3) A bit unsatisfied (4) Very unsatisfied (5) I don't know (6)
V2. Do you trust the health professionals at your primary care center?	No (0) Yes (1)
V3. If you have / had a diverse sexual orientation, have / would you have mentioned your sexual orientation to any of the health professionals at your Primary Care Center?	No (0) Yes (1)
V4. How have you felt about commenting on your sexual orientation to the health professionals at your primary care center?	Very comfortable (1) Comfortable (2) A bit comfortable (3) A bit uncomfortable (4) Very uncomfortable (5) I don't know (6)
V5. Do you think the professionals in your primary care center are LGBT+-friendly?	Very much (1) Quite a bit (2) Just a bit (3) Fair (4) Not at all (5) I don't know (6)
V6. Do you consider that the health professionals in your primary care center and the people who manage the health services are aware of the specific concerns and needs of LGBT+ people?	Yes (1) Just a few (2) No (3) I don't know (4)
V7. Do you use any non-conventional medicine service? (For example, osteopathy, acupuncture, etc.)	No (0)

	Yes (1)
V8. How do you assess your current state of health in general?	Very good (1) Good (2) Fair (3) Bad (4)
V9. How important are the following aspects for your health	
V9a. Cardiac illnesses	Not related to my health (0) Not important at all for my health (1) Not important for my health (2) Unsure about its importance (3) Important for my health (4) Very important for my health (5)
V9b. Assessment of sexual and reproduction health	
V9c. Psychological assessment on depression, anxiety and stress	
V9d. Psychological assessment on self-injury and suicide	
V9e. Psychological assessment on mental or physical harassment	
V9f. Psychological assessment on sexual abuse	
V9g. Psychological assessment on Intimate Partner Violence (IPV)	
V9h. Psychological assessment on low personal or bodily self-esteem	
V9k. Psychological counseling on (my) LGBT condition	
V9l. Counseling on other aspects of emotional health (specify)	
V9m. Have access to provision of measures to reduce risk of infection (for example, clean syringes, filters, safe needle deposits, etc.)	
V9n. Assessment on sexually transmitted diseases (for example, HIV, syphilis, viral hepatitis) and supply of safer sex materials (for example, condoms, protective barriers)	
V9o. Psychological assessment in case of substance abuse (alcohol, other drugs)	
V9p. Advice on healthy aging	
V9q. Have a health-care service for trans people	
V9r. Trans counseling	
V9s. Information on sexuality	
V9t. Assessment on food and healthy eating habits	

Table 3. Satisfaction with the health-care staff		
Item	**Chi Square**	**Cramer's V**
What is your degree of satisfaction with health professionals in primary care centers?	6.310	0.152
Do you trust the health professionals at your primary care center?	0.330	-0.032
If you have / had a diverse sexual orientation, have / would you have mentioned your sexual orientation to any of the health professionals at your primary care center?	18.242***	-0.241***
How have you felt about commenting on your sexual orientation to the health professionals at your primary care center?	42.540***	0.489***
Do you think the professionals in your primary care center are LGBT+-friendly?	7.666	0.156
Do you consider that the health professionals in your primary care center and the people who manage the health services are aware of the specific concerns and needs of LGBT+ people?	1.862	0.078
Do you use any non-conventional medicine service? (for example, osteopathy, acupuncture, etc.)	1.109	-0.060
* P value < 0.05, ** p value < 0.01, *** p value < 0.001 0,05		

Table 4. If you have / had a diverse sexual orientation, have / would you have mentioned your sexual orientation to any of the health professionals at your primary care center?

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
No	40	37.0%	129	62.3%	169	53.7%
Yes	68	63.0%	78	37.7%	146	46.3%
Total	108	100.0%	207	100.0%	315	100.0%

$\chi 2$ (1) = 18.242, p = .000; Cramer's V = -0.241, p= .000

Table 5. How have you felt about commenting on your sexual orientation to the health professionals at your primary care center?

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
Very comfortable	9	8.9%	20	26.0%	29	16.3%
Comfortable	41	40.6%	28	36.4%	69	38.8%
A bit comfortable	23	22.8%	19	24.7%	42	23.6%
A bit uncomfortable	0	0.0%	10	13.0%	10	5.6%
Very uncomfortable	28	27.7%	0	0.0%	28	15.7%
	101	100.0%	77	100.0%	178	100.0%

$\chi 2$ (4) = 42.52, p = .000; φ = 0.489, p= .000

Table 6. In relation to your health, how important are the following aspects to you?		
Item	**Chi square**	**Cramer's V**
Cardiac illness prevention	18.772**	0.214**
Information on sexuality	25,571***	0.250***
Assessment of sexual and reproduction health	30,866***	0.275***
Assessment of food and healthy eating habits	13,713*	0.177*
Psychological assessment on depression, anxiety and stress	5,850	0.120
Psychological assessment on self-injury and suicide	4,605	0.106
Psychological assessment on mental or physical harassment	6,456	0.126
Psychological assessment on sexual abuse	7,310	0.134
Psychological assessment on intimate partner violence (IPV)	4,543	0.106
Psychological assessment on low personal or bodily self-esteem	0,943	0.048
Psychological counseling on (my) LGBT condition	8,934	0.148
Counseling on other aspects of emotional health (specify)	4,885	0.109
Measures to reduce risk of infection (for example, clean syringes, filters, safe needle deposits, etc.)	8,254	0.142
Assessment on sexually transmitted diseases and supply of safer sex materials	5,795	0.119
Psychological assessment in case of substance abuse (alcohol, drugs)	11,36*	0.167*
Advice on healthy aging	9,88	0.156
Have a health-care service for trans people	4,196	0.101
* p value < 0,05, ** p value < 0,01, *** p value < 0.001		

Table 7. In relation to your health, how important are the following aspects to you? Cardiac illness prevention

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
Not related to my health	7	4.7%	16	6.2%	23	5.6%
Not important at all for my health	1	0.7%	6	2.3%	7	1.7%
Not important for my health	9	6.0%	14	5.4%	23	5.6%
Unsure about its importance for my health	13	8.7%	28	10.8%	41	10.0%
Important for my health	36	24.2%	104	40.2%	140	34.3%
Very important for my health	83	55.7%	91	35.1%	174	42.6%
Total	149	100.0%	259	100.0%	408	100.0%

$\chi 2$ (5) = 18.772, p = .002; Cramer's V = 0.214, p= .002

Table 8. In relation to your health, how important are the following aspects to you? Assessment of food and healthy habits

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
Not related to my health	3	2.0%	5	1.9%	8	2.0%
Not important at all for my health	0	0.0%	2	0.8%	2	0.5%
Not important for my health	3	2.0%	11	4.2%	14	3.4%
Unsure about its importance for my health	9	6.0%	16	6.2%	25	6.1%
Important for my health	45	30.2%	115	44.4%	160	39.2%
Very important for my health	89	59.7%	110	42.5%	199	48.8%
Total	149	100.0%	259	100.0%	408	100.0%

$\chi 2$ (5) = 13.17, p = .022; Cramers V = 0.18, p= .022

Table 9. In relation to your health, how important are the following aspects to you? Information on sexuality

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
Not related to my health	4	2.7%	4	1.5%	8	2.0%
Not important at all or not important for my health	7	4.7%	10	3.9%	17	4.2%

Unsure about its importance for my health	15	10.1%	5	1.9%	20	4.9%
Important for my health	33	22.1%	108	41.7%	141	34.6%
Very important for my health	90	60.4%	132	51.0%	222	54.4%
	149	100.0%	259	100.0%	408	100.0%

$\chi 2$ (4) = 25.571, p = .000; Cramer's V = 0.25, p= .000

Table 10. In relation to your health, how important are the following aspects to you? Psychological assessment in case of substance abuse (alcohol, drugs)

	I don't identify as LGBT+		I identify as LGBT+		Total	
Not related to my health	33	22,1%	51	19,7%	84	20,6%
Not important at all for my health	5	3,4%	12	4,6%	17	4,2%
Not important for my health	2	1,3%	17	6,6%	19	4,7%
Unsure about its importance for my health	10	6,7%	16	6,2%	26	6,4%
Important for my health	29	19,5%	70	27,0%	99	24,3%
Very important for my health	70	47,0%	93	35,9%	163	40,0%
	149	100,0%	259	100,0%	408	100,0%

$\chi 2$ (5) = 11,36, p = .045; Cramer's V = 0,167, p= .045

Table 11. In relation to your health, how important are the following aspects to you? Assessment of sexual and reproductive health

	I don't identify as LGBT+		I identify as LGBT+		Total	
	n	%	n	%	n	%
Not related to my health	8	5,4%	36	13,9%	44	10,8%
Not important at all for my health	8	5,4%	17	6,6%	25	6,1%
Not important for my health	6	4,0%	22	8,5%	28	6,9%
Unsure about its importance for my health	6	4,0%	17	6,6%	23	5,6%
Important for my health	30	20,1%	80	30,9%	110	27,0%
Very important for my health	91	61,1%	87	33,6%	178	43,6%
Total	149	100,0%	259	100,0%	408	100,0%

$\chi 2$ (5) = 30,866, p = .000; Cramer's V = .275, p= .000