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Comparing Experiences and Specific Needs of Lesbians, Gays and Bisexuals in Primary Health Care (Catalonia)

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Abstract

In recent decades, the inclusion of sexual and gender diversity has become more important for public policies in primary health care. However, the specific needs of LGB populations still need to be taken into account for effective sexual and gender diversity inclusion. Therefore, we conducted a closed-ended, anonymous online survey that included

sociodemographic questions, perceptions of respondents' health status, their primary health care experiences and their priorities concerning primary health care to identify their specific needs in more detail. The survey received 241 responses in 2018 (including lesbians, gays, bisexual men and bisexual women). In this article, we reveal the similarities and differences concerning perceived health, experiences and priorities in primary health care according to users' sexual orientation. Our results offer new data orientating public policies for LGB individuals in primary health care.

Keywords: Primary health care, LGBT, Public health, Health system, Health providers

1. **Introduction**

Social, economic, and political conditions have been identified as social determinants of health, a fundamental concept that influences the health of individuals and populations (Lucyk & McLaren, 2017). However, despite gaining interest in both politics and science, sexual minorities, such as lesbians, gays, bisexuals, and transgender individuals, are struggling to incorporate their long overlooked realities and identities Health, and especially primary health care, is a central field in this struggle for the inclusion of an LGBT+ perspective (Cruells & Coll-Planas, 2013). In this article we explore to what extent Catalan gays, lesbians and bisexuals have similar experiences in and attitudes towards primary health care, in order to gain insights that might help improve the inclusivity of public primary health care.

Publicly funded universal health care is one of the four key elements of a welfare state (Solanes, 2014) and primary health care is its most accessible part at its lowest level. Primary health care constitutes a right guaranteed by international (Cuadra, 2011), European (Suess, Ruiz, P., Ruiz, A., & March, 2014; Kaczorowska, 2006) and Spanish law (Suess, Ruiz, P., Ruiz, A., & March, 2014; Solanes, 2014). Equality and inclusion in public primary health care is not just a normative duty, but is also recommended by economic analysis as it favours more equal societies (Gough, 2019; Sen, 2002). Lastly, equality in health contributes to social justice by making our society more equal (Sen, 2002). Therefore the analysis of public primary health care is a key element in attempts to achieve a more equal and fairer society, but also a society that obeys its own norms and consensus as well as its aspirations for efficiency.

Considering lesbians, gays and bisexuals (LGB), research and activism have revealed and denounced the explicit and implicit exclusion of LGB and their specific needs from a heteronormative public health care system (Mulé et al., 2009). This exclusion has led to a poorer perceived health status of LGBs (Pérez, Martí-Pastor, Gotsens, Bartoll, Diez, & Borrell, 2015; Conron, Mimiaga, & Landers, 2010) and less probability of accessing primary health care due to the fear of discrimination (Gahagan & Subirana-Malaret, 2018). Medical staff often lack the relevant knowledge, empathy and cultural competence (Colpitts & Gahagan, 2011; Gahagan & Subirana-Malaret, 2018). All this leads to a reduced life expectancy, lower quality of life and an elevated level of acute and chronic diseases (Gahagan & Subirana-Malaret, 2018). The exclusion of gays and lesbians from primary health care due to explicit or implicit homophobia or heteronormativity hits a collective that is over-proportionately affected by psychological diseases (Marti-Pastor, Perez, German, Pont, Garin, Alonso, Gotsens, & Ferrer, 2018; Pérez, Martí-Pastor, Gotsens, Bartoll, Diez, & Borrell, 2015; Cochran & Mays, 2007; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006), and more likely to commit suicide and suffer more substance abuse, anxiety and harm themselves (Elliott et al., 2015; Gahagan & Colpitts, 2017). Thanks to the work of activism and advocacy groups, public primary health care is starting to incorporate a LGBTQ perspective (Leyva-Moral et al., 2018; Marti-Pastor et al, 2018; Pérez et al., 2015; Coll & Cruells, 2013). At the same time though, it is clear that the LGBTQ community is not as homogenous as some claims regarding public policies might suggest. In order to achieve

equality for the LGBT population, health care systems must be aware of their user's differences (Lampalzer et al., 2018), taking into account other axes of inequality (Cruells & Coll, 2013). This article highlights the similarities and differences among Catalan lesbians, gays and bisexuals in terms of their state of health and their specific needs, claims and access to primary health care, as well as their interaction with medical staff.

Concerning the differences between lesbians, gays and bisexuals we know that lesbian and bisexual women suffer more cervical cancer than heterosexual women (Boehmer et al., 2011; Cochran & Mays, 2007; Meads et al., 2012; Meads & Moore, 2013) and have more pronounced psychological and emotional care needs and poorer recovery (Hill & Holborn, 2015). Lesbian women have a higher rate of polycystic ovaries (80% vs. 32%) as well as higher rates of polycystic ovary syndrome (38% vs. 14%) compared to heterosexual women (see Meads et al., 2012) and a higher risk of overweight (Eliason, Ingraham, Fogel, McElroy, Lorvick et al., 2015). Compared to lesbians, bisexuals report poorer mental health, more eating problems and a higher probability of self-harming; they are also more likely to have felt sad/miserable or depressed, and more likely to have felt anxious or nervous (Colledge, Hickson, Reid, & Weatherburn, 2015; Semleyn et al., 2016). Compared to heterosexual people, bisexual women, bisexual men, lesbian women and gay men are – in this order – more exposed to an enduring emotional or psychological condition (Elliot et al., 2015). Gay and bisexual men are twice as likely to report anal cancer (Blondeel et al., 2016; Boehmer et al., 2011b), lack of physical activity (Bourne et al., 2016) and overweight, especially as they become older, compared with heterosexual men (Bourne et al., 2016). Amongst LGB people, gay and bisexual men are at highest risk of attempted suicide, particularly those who are younger, and those with lower educational attainment and lower income (Hickson et al., 2016); they also report higher drug consumption (Bourne et al., 2016; King et al., 2008), a greater probability of heavy drinking (Bourne et al., 2016; Gonzales et al., 2016) and smoking, and a higher risk of dependence (King et al., 2008). In this sense, it is clear that the LGBT+ community is far from homogeneous in their health needs.

Catalonia and Barcelona are of special interest when talking about the inclusion of the perspective of sexual diversity in public policies (Cruells & Coll, 2013). In Spain there is to a certain degree a sexual exceptionalism that "*signals distinction from (to be unlike, dissimilar) as well as excellence (imminence, superiority*)" (Puar, 2007, p. 3) *"through the recognition and incorporation of some, though not all or most, homosexual subjects*" (Puar, 2007, p. 4). Due to pressure from activists, Catalonia approved a law against homophobia (Garc á-Orriols & Flix, 2019; Sadurn í& Pujol, 2015) that aims to improve the way public policies deal with sexual diversity. The left-wing government of Barcelona is making a lot of effort to introduce the perspective of sexual diversity in its policy analysis too. Existing research is mainly based on Barcelona: the results affirm that persons with same-sex desire have worse perceived health, higher presence of chronic diseases and worse mental health; they also affirm that persons with same-sex desire are more frequently usual smokers, heavy drinkers and users of illegal drugs (P érez et al., 2015). Taking into account not desire, but sexual conduct instead, P érez et al. (2015) observed that persons who have had sex with persons of the same sex at least once are more frequently usual smokers and more often users of illegal drugs. In

addition, they found that the LGB population of Barcelona indicates worse health than the heterosexual population (Martínez-Pastor et al., 2018). The authors observed that in contrast to some of their theoretically grounded hypotheses the LGB population scored lower in both physical and psychological health than the heterosexual population (Martínez-Pastor et al., 2018).

The LGB population also presented worse health-related quality of life than the heterosexual population, and gender, chronic conditions, and health-related behaviours play a major role in explaining such differences (Martínez-Pastor et al., 2018). These findings support the need to include sexual orientation in the global agenda of health inequities, and provide helpful information for developing new effective public health strategies promotion, including: education based on sexual diversity, evidence-based public health interventions in the general population to reduce external/social and internalized homophobia, and recommendations for health professionals to improve the LGB population's health.

To sum up, an analysis of specific primary health care needs of the LGBT+ community is urgently needed and differences between the subgroups should also be identified. The Catalan context with its different attempts to address sexual diversity appears ideal to us for this purpose. The main objective of this study was to identify existing differences between LGBT and non-LGBT populations' perceptions of and experiences in the Public Catalan Primary Health Care System. To do this, we examined whether LGBT populations have equal access to the primary health care system and whether they consider themselves to be treated appropriately. We also analyzed their perceived health status and their specific health needs. This article offers innovative insights into these matters as this is one of the first studies of LGBT populations and the Catalan Health Care System. We conclude by making important policy recommendations based on experiences in and attitudes towards the primary health care of Catalan gays, lesbians and bisexuals.

2. Methods

In this section we present the epistemological, methodological and technical bases of our paper. We introduce characteristics of the sample as well as the questionnaire, finishing with some limitations and strengths.

Although this paper addresses public policy on primary health care we focus mainly on perceptions, attitudes, opinions and experiences which are crucial indicators to understand reality. We focus on lesbians, gays and bisexuals, since other sexual and gender minorities of the sample where not enough representative.

In terms of methods we measured perceptions, attitudes, opinions and experiences of lesbians, gays and bisexuals in Catalonia through an online questionnaire. The online survey used in this current research was developed by Gahagan and colleagues for a study of access to primary health care in Nova Scotia (Canada), and modified for use with the Catalan Primary Health Care System (ICS). The 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 impacting LGBTQ health, as well as community consultations in

urban and rural Nova Scotia with community stakeholders (see Colpitts & Gahagan, 2016; Gahagan & Subirana, 2018). The survey consisted of closed-ended questions mainly related to the sociodemographic factors and self-perceived health status, and open-ended questions to explore in more detail the health care experiences of the participants. The anonymous, online survey was completed electronically by selecting radio buttons, checking boxes, and typing in text, depending on the nature of the question. The methodology is mainly deductive as we present our theory and our hypothesis and contrast them via a study of the data (López-Roldán & Fachelli, 2015a). Our data analysis also generates new inputs to complement or adjust the theoretical basis. The analysis follows a distributive or quantitative approach (López-Roldán & Fachelli, 2015b). Technically we rely on contingency tables (Domínguez & Solsona, 2003), crossing the different variables with the variable sexual orientation (lesbians, gays and bisexuals).

Data were collected from a sample of the LGBT and the general non-LGBT populations 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 users of the Catalan Primary Health Care System. A total of 496 participants completed the anonymous online survey, of which 241 were identified as gay men, lesbian women, bisexual women and bisexual men based on their declared sex and the gender they declared themselves to desire.

Table 1. Information on the sample according to sexual orientation

	Frequency	Percentage	Valid Percentage
Gay men	87	17,5	36,1
Lesbian women	43	8,7	17,8
Bisexual women	88	17,7	36,5
Bisexual men	23	4,6	9,5
Total LGB	241	48,6	100
Heterosexuals	255	51,4	
Total participants	496	100	

Using this data we aimed to determine to what extent the experiences and demands of lesbians, gays and bisexuals can be subsumed within the term LGBT+. Therefore we looked for, firstly, similarities and differences in the state of health of Catalan lesbians, gays and bisexuals; secondly, similarities and differences among Catalan lesbians, gays and bisexuals in terms of specific needs and demands; and thirdly, similarities and differences among Catalan lesbians, gays and bisexuals concerning access to health care and interactions with medical staff. In this regard we stress that when we refer to the whole sample we only refer to lesbians, gays and bisexuals (LGB). In this article we do not discuss differences between LGB and straight people.

The central limitation of this research is that it was limited to lesbian women, gay men and

bisexual women and men and did not specifically include transgender individuals. We plan to dedicate a separate paper to this matter as it is an extensive topic (Coll & Miss é, 2015). Also, the online sample was small and not perfectly stratified, which means a younger and overproportionately educated sample, consistent with other research on online sampling (D áz de Rada Iguzquiza, 2011). The methodological strength of this paper is that it is one of the first attempts to detect quantitatively the claims of lesbians, gays and bisexuals related to Catalan primary health care. It is clearly innovative that we generated our own data, which allows us to go beyond the analyses done with relatively small samples and secondary data (Leyva-Moral, 2018; Marti-Pastor et al., 2018; P érez, Mart íPastor, Gotsens, Bartoll, Diez, & Borrell, 2015).

3. Results

In this section we start by considering the state of health of the subgroups, and continue with the ranking of specific needs and claims, also considering the differences among our subgroups. We go on to compare access to public primary health care and interactions with medical staff, satisfaction with and confidence in the professionals in primary health care, and our interviewees' experiences of coming out and the LGBT+ friendliness of their health care centres. We finish with a paragraph on medical coverage.

3.1 Subjective State of Health

According to the self-assessment of the general health status of the interviewees, good health predominates: more than two thirds of the sample evaluated their health status as good or very good. Although there were differences between groups, such as gay men self-assessing their health status as much better than the other subgroups, there were no statistically significant differences between groups.

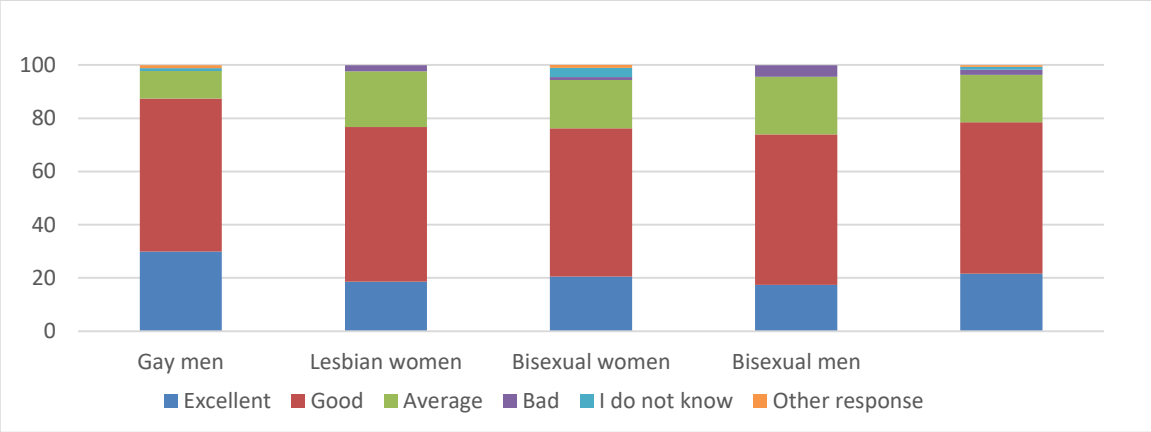

Figure 1. Subjective Health Status according to sexual orientation

3.2 Ranking of Specific Needs and Claims

In relation to the importance (response category 'very important') of different aspects of the personal health of the interviewees, the results were also quite similar between lesbians, gays and bisexuals. Issues related to sexuality (very important 51.3%) as well as those related to

STDs (very important 56.6%) were the aspects that the interviewees found the most important. There were also concerns about psychological counselling. The data highlights the importance of counselling for depression, anxiety and/or stress (50.9% very important), low personal and/or body self-esteem (48.2% very important), violence against a partner (47.8% very important), sexual abuse (46.9% very important), and mental and physical harassment (44.2% very important). Other psychological counselling was less valued, for example counselling on self-harm and/or suicidal ideation (40.7% very important), the LGBT+ condition (37.2% very important) or substance abuse (alcohol, drugs) (35.8% very important). Food and health counselling was considered very important by 42% of those interviewed. Only 38.5% reported good access to measures to reduce their risk of infection (for example, clean syringes, filters, safe needle deposits, etc.), and the same amount believed that a health care service for transgender individuals is very important. A smaller percentage of respondents considered heart disease (35%), reproductive and/or contraception counselling (33.6%) and healthy aging counselling (28.3%) as very important.

Table 2: Importance of different aspects of health

	Not related with my health	Not at all important	Not very important	Unsure	Important	Very important
STD	4.9	2.2	4.4	4.9	27.0	56.6
Sexuality	1.3	0.4	3.1	2.2	41.6	51.3
Depression, anxiety, stress	4.0	1.3	5.8	8.4	29.6	50.9
Low self esteem	8.8	2.2	7.1	7.1	27.4	48.2
Partner violence	19.9	3.1	7.1	6.2	15.9	47.8
Sexual abuse	17.7	3.5	8.0	9.7	14.2	46.9
Harrassment	16.4	3.1	6.6	10.2	19.5	44.2
Healthy habits	1.8	0.9	4.0	5.8	45.6	42.0
Selfharm and suicidal ideas	19.0	7.1	9.3	6.6	17.3	40.7
Access to risk reducing tools	17.3	4.9	6.2	8	25.2	38.5
Service for trans*	24.8	1.3	3.1	9.3	23.0	38.5
Psychologicalassessment on my LGBTQ condition	8.4	4.9	8.8	10.6	30.1	37.2
Substance abuse	18.6	4.9	7.1	6.2	27.4	35.8
Heard disease	5.9	2.2	5.8	11.1	40.3	35.0
Reproduction and anticeonception	14.2	6.6	8.0	7.1	30.5	33.6
Healthy aging	5.3	4	7.1	17.7	37.6	28.3
Emotional health	28.8	3.1	4.0	15.0	20.8	28.3

If we consider not only the 'very important' response category, but also the 'important' response category, the priorities change. Sexuality (92.9%) and STDs (83.6%) are still at the top of the list, but counselling on nutrition and health habits (87.6%) now occupies third place. More than three quarters of the sample considered psychological counselling on depression, anxiety and/or stress (80.5%) and low personal and/or body self-esteem (75.6%) to be highly relevant. For more than two thirds of the sample, counselling about their LGBT+ condition would be important (67.3%), as well as counselling for healthy aging (65.9%).

Reproductive and/or contraceptive counselling (64.1%), counselling about psychological or physical harassment (63.7%), access to measures to reduce the risk of infections (e.g., clean syringes, filters, reservoirs, needles, etc.) and counselling about partner violence (both 63.7%) were also considered important by many of the respondents. Counselling about substance abuse (alcohol, drugs) (63.2%), having a trans* health care service (61.1%) and counselling on self-harm and/or suicide ideation were considered important by similar percentages of respondents. Although in most cases there were no significant differences between the groups, it is important to emphasize where lesbians, gays and bisexual men and women disagreed.

3.3 Differences between Lesbians, Gays and Bisexuals

Regarding sexuality the lesbians surveyed indicated that sexuality was not important at all (2.5% of lesbians versus 0.4% in general) or not very important (10% of lesbians versus 3.1% in general).

In terms of the importance of STD counselling, lesbian women stood out by affirming that this is a matter that has nothing to do with their health: 12.5% compared to an average of 4.9% for all interviewees. A disproportionate percentage of bisexual women also stated that STDs do not matter at all for their health: 5.1% vs. 2.2% in general. Also noteworthy is the percentage of lesbian women in the response category 'not really important': 12.5% of lesbians compared to an average of 4.4%. Bisexual women responded overproportionately with 'uncertain': 10.1% compared to 4.9% of the whole sample. Bisexual women were also less likely to consider STDs important for their health: only 17.7% considered it an important issue while the average for the whole sample was about 27%. Finally, only 42.5% of lesbian women believed STDs are an important aspect of their health, compared to 56.6% of the whole sample.

Gay men disagreed with the other non-normative identities on the importance of depression, anxiety and/or stress counselling: only 41.7% of gay men stated that this was very important versus 50.9% of the whole sample. Regarding partner violence, gay men stood out because they were overproportionately uncertain about whether this matter is important (10.7%), while bisexual women (1.3%) were far less uncertain than the average (6.2%). Gay men also stood out by considering partner violence very important (39.3%) less often than the rest of the sample (47.8%). Regarding sexual abuse, a lower percentage of gay men considered it as very important (36.9%) compared with the whole sample (46.9%). Regarding nutrition and health advice, more bisexual men thought that nutrition and health advice has nothing to do with their health (8.7%) than in general (1.8%). Bisexual women were less uncertain about the need for transsexual health services* (3.8%) than the whole sample (9.3%). Attitudes

towards psychological counselling on the LGBT+ condition also differed: bisexual women (3.8%) believed to a much lesser extent than the whole LGB sample (8.8%) that psychological counselling on the LGBT+ condition is not a very important issue; in the uncertain response category, lesbian women were overrepresented (22.5%) compared to 10.6% for the whole sample. And gay men (21.4%) believed to a lesser extent than whole sample (30.1%) that this is an important health issue.

In terms of reproduction and contraception, gay men were clearly overrepresented among those that thought this was not an issue (25%), while bisexual women were underrepresented (3.8%), the average being 14.2%. Gay men also stood out among respondents who considered that reproduction and contraception were of no importance to them (14.3%) compared to an average of 6.6%. In the 'uncertain' response category both men and bisexual women deviated from the average (7.1%): bisexual women considered the importance of reproduction and contraception as uncertain less often (2.5%), while bisexual men were uncertain much more often (21.7%). Regarding the respondents that considered reproduction and contraception an important aspect of their health, gay men were underrepresented (21.4% versus 30.5% overall); they were also underrepresented among those who thought this issue very important to their health (22.6% versus 33.6%), as were bisexual women (48.1%). Gay men and bisexual women also differed in whether they considered aging 'very important': while 28.3% of the sample considered dignity in aging very important, the percentage was 36.9% for gay men and only 20.3% for bisexual women.

3.4 Access to Public Primary Health Care and Interaction with Medical Staff

In the case of LGBT+ we consider that access to health care is strongly related to relationships with the medical staff, especially in terms of trust and confidence. Therefore, in the following section we discuss general satisfaction with the professionals working in primary health care and confidence in them. Given that coming out is an important issue for trust, and also for diagnosis, we asked the participants if they had revealed their sexual orientation to the staff and if not why not. We also wanted to know whether they considered their primary health care centre LGBT+ friendly. We also asked directly if they had experienced discrimination and or if they had received positive attention due to being LGBT+. Finally, we tried to assess medical coverage by asking if they used alternative medicine or if they had private health insurance.

3.5 Satisfaction with and Confidence in the Professionals in Primary Health Care

Regarding the degree of satisfaction with the professionals in primary health care, we observed high satisfaction overall (N = 151): the bulk of the responses in all subgroups were 'satisfied', 'somewhat satisfied' and 'very satisfied'. Dissatisfaction was highest among bisexual women, especially in the 'somewhat dissatisfied' response category (19.2% versus 11.3% on average). Bisexual women also reported being less often highly satisfied with primary care professionals (5.8% versus an average of 15.9%).

Regarding LGBT respondents' trust in the primary health professionals, more than 70% of the sample trusted them (N = 185). However, more than 40% of bisexual women reported

distrusting the staff. The high rate of distrust in the case of bisexual women, and the 20% rate of distrust in the case of lesbians, gays and bisexual men, is quite alarming.

Coming out

Distrust also influences decisions made by LGBT+ to share their sexual orientation with health professionals (N = 194). It is noteworthy that most of the respondents had never shared their orientation with health professionals (59.8%). Particular mention should be made of bisexual men, among whom only 15% had openly spoken about their sexual orientation with medical staff.

Those people who had informed the staff about their sexual orientation (N = 75) were mostly comfortable (37.3%) and very comfortable (25.3%) doing so. However, a substantial proportion of the sample indicated having felt a little (25.3%) or very uncomfortable (12%). There were no statistically significant differences between gay men, lesbian women, and bisexual men and women. People who had not shared their sexual orientation with CAP staff (N = 191) gave a number of reasons for this: most interviewees stated that it was not relevant for the care they needed at the time (58.1%). In this category of response lesbian women were overrepresented (78.1%), while bisexual men were underrepresented (35%). More than a quarter of the interviewees said they did not feel the need to comment on their sexuality (25.1%), with lesbian women being under- (9.4%) and bisexual men over-represented (50%). Twelve percent of the sample said they were afraid of inappropriate comments, with lesbian women standing out in this respect (19.1%). Less than 5% of the interviewees said they knew that the staff would not react appropriately.

LGBT+ friendliness of the primary health care centre

When asked about the LGBT+ friendliness of the professionals most of the answers were ‘I do not know’ (44.3%), followed by ‘quite friendly’ (28.1%), ‘a little’ (13%) and ‘not at all’ (28.1%). It is clear that bisexual women were much less satisfied, with only 1.6% reporting that they were very satisfied and 15.6% quite satisfied, while 54.7% of them were uncertain (54.7%) regarding the friendliness of the staff. The very high degree of uncertainty also reflects the difficulty of translating the idea of LGBT+ friendliness into Spanish and Catalan.

Regarding whether health professionals are aware of the specific concerns and needs of the LGBT+ population (N = 185), most respondents answered yes, although they thought that not all of their specific concerns and needs were understood (49.2%). Almost a quarter of the sample responded that they did not know, which could be attributed to doubts concerning the term ‘specific needs’. Another 17.3% said that CAP health professionals do not understand the specific concerns and needs of the LGBT+ population, and only 7.6% affirmed that all the specific concerns and needs were covered. The responses of bisexual women, and also gay men, were noteworthy: while the former were very unlikely to believe that medical staff are aware of the specific needs and concerns of the LGBT+ population (1.6%), gay men were strongly overrepresented (13%) in believing that LGBT+ issues are understood.

Among the whole sample, 16.2% of respondents reported that they had been discriminated against by medical staff, while the vast majority had had no experience of discrimination due

to their sexual orientation (N = 185). Although lesbian women stood out for having received more LGBT+-phobic discrimination, there were no statistically significant differences between the sub-groups.

When asked if the respondents had ever received positive attention from a professional (N = 185), because of being LGBT+, 88.1% of respondents said no, while 11.9% of respondents said yes. Lesbians stood out in this respect (24.2% had received positive attention).

Medical coverage

In an attempt to identify strategies used in addition to public primary health care in response to the latter's insufficiencies, we asked whether the respondents used alternative medicine and/or private health care. Concerning alternative medicines (N = 185), the vast majority of the sample had not used non-conventional medicine (81.1%). Of the fifth that had used non-conventional medicine (18.90%), lesbian women stood out (33.3%). Most of the respondents did not have private health insurance.

4. Discussion

Summing up the results we found that generally speaking there were few differences between gays, lesbians and bisexuals in the evaluation of primary health care. First of all, we would like to mention that the subjective state of health of the sample was quite good and did not vary between lesbians, gays and bisexuals. Considering that perceived health status and objective health are assumed to correlate, this contradicts some previous studies that observed important differences (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Gonzales, Przedworski, & Henning-Smith, 2016). In this sense, it seems clear that the introduction of gender identity in addition to sexual orientation could be very enriching for future research.

Secondly, for the entire LGBT+ community sexuality itself, sexually transmitted diseases (STDs) and psychological counselling are very important elements of primary health care, the latter reflecting the higher probability of psychological problems in the LGBT+ community compared with the general population (Marti-Pastoret al., 2018; Pérez, Martí-Pastor, Gotsens, Bartoll, Diez, & Borrell, 2015; Cochran & Mays, 2007; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006). The concerns about STDs might be explained by the young average age of our sample or the lack of or inadequate treatment of them, with gay and bisexual men being disproportionally affected by STDs (Jacques-Aviñó et al., 2019; Leyva-Moral et al., 2018). In our sample psychological counselling mainly involved counselling for depression, anxiety and/or stress, low personal and/or body self-esteem, violence against a partner, sexual abuse and mental and physical harassment, with counselling for self-harm or suicidal ideation, LGBT+ condition or substance abuse being less frequently mentioned. Surprisingly these are some of the issues that particularly affect the LGBT+ community, who are more likely to commit suicide and suffer more substance abuse, anxiety and self-harm than the general population (Elliott et al., 2015; Gahagan & Colpitts, 2017). Heart disease, reproductive and/or contraception counselling and healthy aging counselling were not among the greatest worries in the setting of public primary health care.

Our results confirmed serious problems in terms of trust, satisfaction, awareness of specific needs of the LGBT+ community and discrimination, as also observed in similar studies (Gahagan & Subirana-Malaret, 2018). Trust in the employees in primary health care seemed relatively high, but not as high as it should be – and quite similar to that reported by heterosexuals (under revision: Subirana, Freude, & Gahagan, 2020); mistrust towards primary health care staff was greater among bisexuals. Coming out in front of primary health care personnel certainly requires trust. But most of the respondents and especially bisexual men have never outed themselves 'at the doctors', alleging that sharing their sexual orientation has not been relevant for their treatment, but 5% also feared inappropriate reactions by the staff. We know that awareness about the sexual orientation of the patient may help the diagnosis, although institutions and researchers should respect the patients' right to privacy. In order to encourage users to come out it is important to stress that the majority of LGBT+ who had come out felt comfortable or very comfortable doing so. It is also important to identify the factors that made some individuals feel uncomfortable, so that these difficulties may be overcome. It is worth mentioning that there were no statistically significant differences between lesbians, gays and bisexuals who experienced their coming out at the primary health care center: our results indicate that they were faced almost equally by homophobia or tolerance. Regarding discrimination, we observed that a noteworthy minority of 16.2% experienced discrimination – and this should be combatted strongly because it hinders advancement in democratic health care systems. Again we noticed that homophobic discrimination did not distinguish between lesbians, gays and bisexuals – all of them perceived it more or less indistinctively.

Although there were common experiences and a general consensus on the LGBT+ agenda for public primary health care, we also observed fine differences. All the interviewees considered that public primary health care addresses some but not all of the specific concerns and needs of the LGBT+ community. Regarding the LGBT+ friendliness of the primary health care system, the interviewees were generally satisfied, although bisexual women scored lower satisfaction rates. In the following paragraphs we outline some of the needs that should be addressed in order to gain approval from all of the collectives who form the LGBT+ community.

Gay men considered reproduction and contraception counselling less important than bisexual and lesbian women, while bisexual men were more uncertain about this issue. Likewise gay men did not think that counselling on partner violence, depression, anxiety and/or stress, the LGBT condition or sexual abuse is that important.

Lesbians considered sexuality and sexually transmitted diseases a less important issue of public health, placing more importance on reproduction and contraception. Bisexual women were more uncertain regarding the place STDs should occupy in public health and less uncertain about the place of counselling on reproduction and conception, which they consider more important.

Bisexual men considered nutrition and health advice a peripheral issue and were more uncertain about reproduction and contraception counselling.

These results on preferences are complemented by practices: more than a fifth of our sample reported using alternative medicine, which suggests that they were looking to satisfy their needs elsewhere – not in public primary health care. Here, lesbians were overrepresented, suggesting that they have more urgent needs. These escapees from the public system indicate insufficiencies that need tackling, because the evasion of public services through private and alternative measures by some destabilizes the public system as a whole in the long run.

These splits in the LGBT+ community force us to think in a less hermetic and more intersectional way. In general terms, gender remains a crucial variable that needs to be considered alongside sexual orientation and sexual practices; and sexual orientation or practices cannot be reduced to LGBT+ and non-LGBT+ as differences in the minorities must be addressed.

According to previous research, STDs are a major concern in Catalonia (Ventura, Rodr ́guez-Polo & Roca-Cuberes, 2019); however, our data showed that STDs are principally considered as very important by gay and bisexual men. Given that lesbian and bisexual women give much more importance to reproduction and contraception, we need to take into consideration that the common critique that the LGBT+ community is coopted by gay men is also true in the case of public primary health care claims. On the other hand, our data provides sensible information on the low importance gay men give to reproduction and contraception, contrasting with the public debate on surrogacy. Here the LGBT+ community and especially gay men are instrumentalized by the defenders of the legalization of surrogacy in Spain (Jacques-Avi ñó et al., 2019; Ventura, Rodr ́guez-Polo & Roca-Cuberes, 2019; Arando et al., 2019; Leyva-Moral et al., 2018), although our data suggests that reproduction is not such an important issue for this collective.

Coming back to STDs in primary health care we wonder whether our gay interviewees had mainly experienced the centralized treatment of STDs in a special primary health care centre in Barcelona city, where all cases are automatically directed. Although this means that patients receive highly specialized and mainly respectful attention it also implies almost no valid information about the rest of the city's primary health care centres. This tendency for centralized treatment is reinforced by the policy of putting in charge non-profit third sector NGOs to detect STDs. Finally, we should consider that our results might indicate an oversensitivity regarding STDs in the gay community.

5. Conclusions

In this study we aimed to determine the differences and similarities in the experiences and claims of lesbians, gays, bisexuals and trans* in public primary health care in Catalonia. Firstly, we observed that there were no significant differences in the subjective evaluation of health status between lesbians, gays and bisexuals and an overall good perceived health status. Secondly, we found that sexuality, STDs, psychological counselling and nutrition and healthy habits were considered important elements of primary health care by our interviewees. Thirdly, we detected considerable problems in trust and confidence with the staff and even open discrimination. And, last but not least, we observed that our sample considered that not all needs of the LGBTQ+ community were covered and that some of them used

non-conventional medicine.

In terms of differences concerning the importance given to different items of primary health care we observed many small differences but two of them stood out: gay and bisexual men considered STDs more important than other subgroups, while bisexual and lesbian women considered reproduction and contraception more important. Thinking about problems with trust, satisfaction and coming out we note the distrust and lack of LGBT+ friendliness perceived by bisexual women, as well as the low outing rate in bisexual men. Finally, in terms of medical coverage, lesbians were the most likely to see options outside orthodox medicine, indicating insufficiencies in the primary health care catalogue.

These results imply firstly that the public health care sector needs to ensure the confidence and satisfaction of all of its patients, and create environments that are LGBT+ friendly, permitting coming out for everyone. Also, public administrations need to be reminded that the LGBT+ community is not homogeneous but crossed by other axes incorporating a LGBTQ+ perspective. We observed that gender was a central element here. Public administrations and social pressure groups do well to represent all the claims of lesbians, gays and bisexuals: the high importance of STDs in LGBT health policies suggests co-option of LGBT+ by gay and bisexual men; we advocate for the inclusion of reproduction and contraception as well. However, the importance of STDs in primary health care makes sense considering that at least in Barcelona the treatment of STDs is concentrated in one centre; our results suggest mainstreaming or transversality, instead of centralization.

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