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LGBTQ2 Health in Canada: Study brief for the Standing Committee on Health

*SUBMITTED BY RAINBOW HEALTH ONTARIO, A PROGRAM OF SHERBOURNE HEALTH
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About Rainbow Health Ontario

Rainbow Health Ontario (RHO) is a program of Sherbourne Health. Unique in Canada, RHO creates opportunities for the health care system to better serve LGBT2SQ communities. RHO achieves this through supporting clinical practice and organizational change – including through providing training, consultation, and coaching - through public policy work, catalyzing research, and knowledge translation. Sherbourne Health is a dynamic provider of integrated health services, community programs and capacity-building initiatives that enable people and diverse communities to achieve wellness. As an urban health agency in downtown Toronto, Sherbourne provides holistic primary care and chronic disease management, mental health services, health promotion and education, and outreach and social supports. Sherbourne’s doors are open to everyone, with a focus on the LGBT2SQ community, homeless and under-housed people and newcomers to Canada, whose complex needs are often not met by traditional health care.

Background

LGBT2SQ (lesbian, gay, bisexual, trans, Two-Spirit, and queer) people represent a significant portion of Canadians. In the United States, adults’ disclosures of sexual orientation and/or gender identity to surveyors have increased from 2.7% in 2008 to 5.4% in 2016, with 7.3% of millennials disclosing an LGBT identity; increasing rates of disclosures are correlated with less social stigma and greater legal protections.¹ Given Canada’s population of 37 million people,² a 7.3% estimate translates to 2.7 million Canadians, while a more conservative estimate at 5.4% translates to 2.0 million Canadians.

LGBT2SQ communities are diverse, and within-group differences can be significant across sexual orientations and gender identities. Issues faced by Indigenous LGBT2SQ people, racialized people, newcomers to Canada, Francophones both inside and outside of Quebec, and/or LGBT2SQ people living in rural and remote communities can all have their own characteristics and can be more complex. If we do not consider these differences, we will not be able to effectively reduce disparities between LGBT2SQ Canadians and other Canadians—in addition to those within different parts of LGBT2SQ populations—to advance the health and well-being of LGBT2SQ people as a whole.

Health disparities

The very limited Canadian data about LGBT2SQ populations points to some significant disparities, avoidable costs for health care and losses in productivity as well as GDP. This brief addresses a few specific examples: mental health, substance use, chronic disease, HIV and STBBIs, unmet health needs, and access to competent care. Nothing inherent to LGBT2SQ identities causes these disparities. Contributing factors include family and societal rejection; higher rates of childhood sexual and physical abuse; and the violence, stigma, prejudice and discrimination that LGBT2SQ people experience.³⁻⁶ These factors are also linked with higher rates of homelessness and poverty, which are also significant determinants of health.⁷⁻¹⁰ Moreover, LGBT2SQ people experience workplace challenges;¹¹ trans people experience significant barriers to employment and high poverty rates.¹²

Mental health and substance use: In Canada, LGBT2SQ people are significantly more likely to experience a variety of mental health concerns compared with their straight and/or cisgender counterparts, including unmet mental health needs, fair or poor mental health, mood and anxiety disorders, and suicidal ideation and attempts.¹³⁻¹⁷ In many cases, the burdens appear to be greatest

for trans people and bisexuals.¹³⁻¹⁷ International studies place rates of substance use for LGB populations at 2-4 times that of the broader population,¹⁸ with risks being higher for lesbian and bi women than gay and bi men.^{18,19} Rates for trans people have also been found to be about 2.5-4 times the rates of the general population.^{21,22} In Canada, bisexual women have been found to use cannabis at more than 5 times the rate for Canadian women overall.²⁰ LGBT2SQ populations also experience differences in the use and misuse of prescription pain relievers,²³ including opioids.²⁴

Chronic diseases: There are significant differences in risk behaviours for cancer, cardiovascular and respiratory diseases in LGBT2SQ populations compared with heterosexual populations.²⁵⁻²⁷ The limited data available also indicates a greater prevalence of chronic diseases such as arthritis,^{28,29} cardiovascular disease, cancer,²⁶ and respiratory disease³⁰ in parts of LGBT2SQ communities. Furthermore, the onset is earlier for LGB people for some disabilities and chronic conditions.^{28,30} Within LGB populations, lesbians and bi people tend to carry a greater health burden.^{26,27,31}

HIV and STBIs: In Canada, gay, bi, and other men who have sex with men continue to be disproportionately affected by HIV³² and other sexually transmitted and blood-borne illnesses.³³ International data indicates that trans women are also disproportionately affected.³⁴

Unmet health needs: Canadian data points to a range of unmet health needs, particularly for lesbians, bi people^{16,35} and trans people.³⁶⁻³⁹ Unmet needs can be higher for racialized LGBT2SQ people.⁴⁰ Internationally as well as in Canada, health care providers are seeing significant increases in the number of trans people presenting for care.^{41,42} For trans adolescents, access to puberty-blocking medications is particularly time sensitive, and delays can result in completely irreversible changes as well as changes that require later medical intervention. As it stands, the clinics who serve these teens are struggling to keep up with the demand. RHO is aware that in Ontario clinics serving these youth, the wait for care is usually one to two years. Additionally, RHO is aware that in Ontario, trans adults are experiencing lengthy waits (often one to two years) for the most-requested transition-related surgery; capacity at surgical facilities is a contributing factor.

Access to competent care: In 2017, Canada had about 875,000 people in the health care workforce.⁴³ Past studies have shown that most medical schools provide 0-8 hours of instruction on working with LGBT2SQ patients.⁴⁴ A recent study found significant gaps in curriculum in Canadian nursing schools, with only half the schools addressing barriers to accessing care and chronic diseases relevant for LGBT2SQ populations.⁴⁵ A sizeable proportion of LGBT2SQ people are not out to their health care provider, or avoid care altogether.⁴⁶⁻⁴⁹ This is often attributed to previous experiences and fears of discrimination. Issues with access to competent care are also influenced by organizational and structural considerations.⁵⁰

Interventions to improve health outcomes: Aside from HIV and STBI prevention and treatment, Rainbow Health Ontario is aware of a very limited number of interventions in Canada that address LGBT2SQ people's health needs. Universal interventions can inadvertently increase health disparities, through providing disproportionate benefit for groups that are at lower risk for poor health outcomes.⁵¹ A proportionate universalism approach can be used to increase the intensity of interventions in response to greater health burdens.^{52,53} In the context of LGBT2SQ health, some

programming may simply need adaptations to be inclusive, while specialized programs and interventions are also needed.

Economic benefits of reducing disparities

Rainbow Health Ontario commissioned a study to examine the cost savings and broader economic benefits that could be achieved in Ontario if the health care burdens and disparities experienced by LGBT2SQ communities were eradicated. The only health systems costs for Ontario that could be calculated, due to limited data, were for lesbian and bi women with breast, colorectal, and cervical cancer. The annual costs to Ontario's health system for treating these three forms of cancer for lesbians and bi women is \$43.7M-\$190.9M. The savings in health systems expenditure that could be achieved by lowering the prevalence rates to those of straight women is \$9.7M at the low end of prevalence and cost-per-case estimates to \$65.0M at the high end.

Differences in rates for these forms of cancer cost an estimated 70 disability-adjusted life years annually for lesbian and bi women, which translates to \$3.8M-\$11.6M in losses to Ontario's GDP. Disability-adjusted life years that were in excess of general population levels were calculated for mental health (depressive disorders, mood and anxiety disorders for LGB populations, and suicidality for trans populations); LGBT Ontarians lost 1,611 disability-adjusted life years annually due to excess risk; this represents an \$88.8M-\$266.3M annual loss in GDP.

Recommendations to address health disparities

1. Address health disparities and determinants of health for LGBT2SQ populations through the lens of proportionate universalism, including through funding, evaluating, and sharing the results of targeted interventions. Within this:
 - a. Develop inclusive as well as targeted interventions in relation to mental health, substance use, chronic diseases and care for transgender populations, as well as other disparities that emerge with better data;
 - b. Increase supports for parents and families of LGBT2SQ people;
 - c. Address violence, discrimination, and hate crimes that target LGBT2SQ populations, including through the National Crime Prevention Strategy, as well as through initiatives driven by provinces and territories, municipalities, and education systems;
 - d. Address poverty and homelessness and other determinants of health for LGBT2SQ populations through federal, provincial, territorial, and regional strategies and initiatives.
2. Ensure LGBT2SQ issues are included in national, provincial and territorial health strategies and initiatives (e.g. mental health, substance use, suicide, home care, dementia, pain, etc).
3. Fund, evaluate, and share the results of initiatives designed to improve health care organizations' and individual providers' abilities to provide clinically competent and culturally safe care for LGBT2SQ populations across the lifespan.

Data and research needs

Very little Canadian data is available through national surveys and tools, health care and other administrative data, and research. This limits on our ability to understand, track changes in, and develop appropriate interventions to improve the health and wellbeing of LGBT2SQ populations,

including in government-led strategies and initiatives to address health priorities. It also limits our ability to understand potential savings and return on investments, and other economic impacts.

National surveys and tools: At present, Statistics Canada gathers very limited data regarding sexual orientation and no data on gender identity, though foundational work to collect gender identity has been completed.⁵⁴ Canada has made a significant investment in both the development of a new Centre for Gender, Diversity and Inclusion and in being able to track health inequalities through the development of the Pan Canadian Health Inequalities Tool.²⁹ However, only a small portion of the indicators in this tool can currently be stratified by sexual orientation, and no data is available by gender identity. Available data indicate a number of significant disparities for LGB populations, yet no data is currently available regarding mortality and life expectancy, mental health or suicide. Very limited data is available in relation to morbidity and disability or specific diseases and chronic health conditions. The utility of the Health Inequalities Data Tool can be improved by ensuring more of the data sources that feed into the tool collect information about sexual orientation and gender identity. While at least seventeen data sources are used in this tool, only two of these sources currently include data related to sexual orientation.²⁹

Health Information Management systems: Rainbow Health Ontario has frequently heard from agencies that key structural challenges for providing competent care are rooted in health information management software. This includes electronic medical records used in doctors' offices and hospitals, as well as laboratory information systems and diagnostic imaging information systems. These software systems commonly lack appropriate fields to capture information about sexual orientation or gender identity in addition to lacking fields for sex assigned at birth, a person's pronouns, the name in use, or an organ inventory.⁵⁵ The lack of these fields can result in barriers to clinical care, lack of appropriate screening, and trans people being misgendered or outed due to information on their wristbands or being called by their legal name rather than their name in use. Agencies don't know what fields to request, and cost can be a barrier for software customization; customization also carries the likelihood that administrative data regarding LGBT2SQ populations cannot be aggregated across agencies. Since there have been recent calls in the *Canadian Medical Association Journal* to develop a pan-Canadian Electronic Health Record for primary care,⁵⁶ developing and implementing data standards related to sexual orientation and gender identity in health information management software may be a key priority.

Health care administrative data: Health administrative data, otherwise known as health care utilization data and health care billing records, is generated at every point of care and interaction in the health system⁵⁷ and is collected by provincial and territorial governments. The Canadian Institute for Health Information (CIHI) plays a key role in Canada through providing repositories of health care administrative data. CIHI has begun work to address health equity, including through defining stratifiers for measuring health inequity. However, at present neither sexual orientation nor gender identity are available within the 13 data sources collected by CIHI.

Research: In Canada, the vast majority of LGBT2SQ health research has focused on HIV and/or mental health. Rainbow Health Ontario is leading consultations to inform a research strategy to advance the health of LGBT2SQ Ontarians. Strategic issues that surfaced to date included funding, knowledge mobilization, capacity building, and the need for community involvement in designing, planning and conducting research. Identifying priority research areas is in progress.

Recommendations regarding data and research

1. In all federal, provincial, and territorial surveys, implement collection, analysis, and reporting on consistent demographics questions related to sexual orientation, gender identity, and other health equality stratifiers that enable comparison across data sources and jurisdictions for tracking of health disparities, health outcomes, determinants of health, experiences in the health care system, and health system costs. Within this:
 - a. Ensure sampling strategies allow for sufficient sample sizes regarding LGBT2SQ populations to allow for disaggregation, including by race / ethnicity
 - b. Prioritize data sources that feed into the Pan Canadian Health Inequalities Tool
 - c. Monitor and report regularly on health disparities, economic impacts, including trends.
2. Engage with key stakeholders in LGBT2SQ health to determine additional question areas (e.g. attitudes towards LGBT2SQ people) that should be included in governmental surveys.
3. Ensure that when individuals register for or renew their provincial or territorial health insurance coverage (e.g. Ontario Health Insurance Plan), administrative data – using consistent definitions - is collected regarding sexual orientation and gender identity and other health equity stratifiers. Engage LGBT2SQ communities in developing and implementing these plans, in order to address concerns related to privacy, trust, and need for data.
4. Implement the reporting of data regarding sexual orientation and gender identity in data sources that are maintained by CIHI. Priorities should include the Hospital Morbidity Database, patient experience reporting, and the Primary Health Care EMR Content Standard.
5. Significantly increase funding for LGBT2SQ health research, knowledge mobilization, policy-research partnerships, and capacity building for engaging in LGBT2SQ health research, for researchers, trainees, and community participants. Within this, focuses for research should include: population health, improving clinical care, improving health systems, the impact of interventions, and determinants of health. Research also needs to focus on lesbian, bi, trans, and Two-Spirit people, especially people who are Indigenous, racialized, newcomers, Francophones, living in smaller cities and communities, and/or who are experiencing poverty.

Recommendations for a systemic approach

A strategic and systemic approach is needed to have the greatest impact in reducing health disparities, improving health outcomes, and achieving related social and economic benefits. Specifically, RHO recommends that:

1. The federal government convenes a table with representatives from other Canadian jurisdictions, key stakeholders from health-focused LGBT2SQ programs and organizations, and other key organizations to advance these recommendations.
2. The federal government makes provisions for LGBT2SQ health in transfer funding agreements, and cultivates the conditions for provinces and territories to meaningfully address LGBT2SQ health.

3. That the Government and the Canadian Institutes of Health Research organize a Best Brains Exchange on LGBT2SQ health and policy issues.

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