Association of Ontario Health Centres
Community-governed primary health care

Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

Rainbow Health Ontario
Santé arc-en-ciel Ontario
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Rainbow Health Ontario and Association of Ontario Health Centres

Joint Submission on *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

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Contacts:

Anna Travers, MSW
Director, Rainbow Health Ontario
Sherbourne Health Centre
333 Sherbourne Street
Toronto, Ontario M5A 2S5
Tel: 416.324.4168

Leah Stephenson
Director, Policy & Stakeholder Relations
Association of Ontario Health Centres
500-970 Lawrence Avenue West
Toronto, ON M6A 3B6
Tel: 416.236.2539 x244

For more information and resources on LGBT health, visit: www.RainbowHealthOntario.ca

Introduction

The authors of this document applaud the overarching theme of improving health equity and reducing health disparities in *Patients First*. We specifically wish to highlight the importance of applying a lens to this document that considers the needs and goals of the LGBT community.

In each of the highlighted populations (Indigenous peoples of Ontario, Franco-Ontarians, other cultural groups and newcomers, and people facing mental health and addictions challenges) as well as the general population, there is a subgroup of people who describe themselves using terms such as lesbian, gay, bisexual, transgender, two spirited, queer, non-binary, gender diverse, etc. In this document, we will use the acronym LGBT to include all these groups.

Like other marginalized groups, LGBT people experience specific health disparities compared with the general population as a result of specific needs that may be different and also as a consequence of discrimination and social isolation. This extends to the health system itself. Therefore, systems of planning and accountability need to explicitly take the needs and perspectives of LGBT people into account in conjunction with other types of marginalization.

As such, our first recommendation is:

1. **Because LGBT individuals are within every part of our society, they require a specific focus in planning and accountability to ensure they are not invisible within the system. To facilitate this, the Ministry implement an intersectional approach to understanding health equity and equity-seeking groups.**

   We deeply appreciate the fact that the *Patients First Proposal* highlights and embeds the importance of health equity as a key element for health system transformation. It is crucial to point out that LGBT individuals are within every part of our society – from racialized to people living with mental health and/or addiction challenges to Indigenous to Francophones to seniors and beyond. The issue of invisibility is especially relevant for LGBT communities as many community members are not recognized as such and are often assumed to be straight or cis-gendered (non-trans). Furthermore, many people are still reluctant to ask about sexual orientation and gender identity, thinking that there is something shameful about being LGBT or because they themselves are uncomfortable. Finally, LGBT people are sometimes reluctant to come out due to concerns about safety. When the context for asking about sexual orientation and gender identity makes sense and confidentiality is assured, this is less of a concern.

   Intersectionality is the study of intersecting social identities and related systems of oppression, domination or discrimination. Complementing health equity, this approach seeks to examine how various biological, social and cultural categories, such as gender, race, class, ability, sexual orientation, religion, age, and other axes of identity interact on multiple and simultaneous levels. Within the LGBT community itself a diversity of identities

exists: lesbian, gay, bisexual, fluid, transsexual, transgender, intersex, queer, questioning, two spirit, asexual, to name a few. Indeed, one person lives with many identities simultaneously (e.g. gender identity, age, race, ethnicity); many of these identities can change over time; and some identities have oppressive worldviews associated with them (e.g. heteronormativity, ageism, racism), all of which compound a person's experiences of oppression and increases their vulnerability to health disparities and poor health outcomes.

As a result, an intersectional lens is essential to ensuring health system planners, funders and providers do not let anyone fall through the cracks of the system and address the complexity of people's experiences. Fortunately, an evidence-based Intersectionality Based Policy Analysis Framework[1] has recently been developed, which can support the Ministry of Health and Long-Term Care and other health system stakeholders in using an intersectional lens in their work.

2. **For LGBT individuals, it is important that the system and providers recognize that their health needs are more than just sexual health. The whole person's needs must be addressed throughout their lifetime. As a result, culturally competent primary health care, such as that provided in many CHCs, AHACs, Community FHTs and NPLCs, is needed as a network across Ontario.**

From womb to tomb, LGBT people and their families have distinct needs that require care by a range of knowledgeable and culturally competent providers. This includes pre-birth (e.g. LGBT individuals becoming parents), children (e.g. gender-independent children), youth (e.g. a teenager feeling suicidal because of bullying), adults (e.g. a lesbian seeking help with substance use, or a gay man seeking treatment for intimate partner violence, or a trans man seeking hormone treatment) and seniors (e.g. a two spirit woman receiving home care or entering a long-term care facility, or a personal support worker entering a lesbian's home). In addition, the whole person needs to be addressed. LGBT health is often viewed through the narrow lens of sexual health or HIV – for example in public health programs. However, the full range of physical, mental and emotional supports are required throughout their lifetimes.

LGBT people are at increased risk for certain health conditions due to the effects of social isolation, discrimination, poverty and gaps in the health care system. Common health disparities include mental health and substance use issues, tobacco use, certain cancers, body image and eating issues, musculo-skeletal problems, STI's and the uptake of screening procedures (Institute of Medicine, 2011). Trans people tend to experience the greatest difficulty in obtaining respectful and appropriate health care due to their specific needs and the high levels of discrimination in society at large (Ryan et al 2008).

Primary health care, such as that provided in many CHCs, AHACs, Community FHTs and NPLCs, delivered by culturally competent providers trained in working with diverse LGBT

[1] See pages 33-45 at http://www.sfu.ca/iirp/ibpa.html

people is needed. Mable and Marriott (2002) state that primary health care (as distinct from and additional to primary care) "recognizes the broader determinants of health and includes coordinating, integrating, and expanding systems and services to provide more population health, sickness prevention, and health promotion, not necessarily just by doctors. It encourages the best use of all health providers to maximize the potential of all health resources."

A network of such culturally competent primary health care providers is needed across Ontario. This is particularly the case in rural, Northern and remote Ontario.

Through the work of Rainbow Health Ontario with members of the Association of Ontario Health Centres, this network is in formation. However, additional training and support is needed to ensure that LGBT people are welcome in all health care settings, including primary care, acute care, home care and long-term care.

3. **Trans care needs to be a core function of primary care.**

According to the World Professional Standards of Care for Transgender Health, most services for transgender health should be provided in primary care or community settings (Coleman et al, 2011). These services commonly include support for trans people and their families, hormone treatment for some, supportive counselling or group programs and pre- and post-surgical care. Upcoming changes in the regulations regarding referrals for transition related surgeries will mean that primary care teams will also be expected to assess readiness and refer their clients for a variety of surgeries rather than sending them to a centralized gender identity clinic.

While the number of people coming out as transgender is now believed to be around one in two hundred and growing (Gates, 2011), the core curriculum being offered to new doctors, nurses or social workers does not include education on how to provide care or support to trans clients. In fact, North American medical schools provide an average of only five hours of education on LGBT health altogether (Obedin-Maliver, 2011). This represents a huge opportunity for change.

For the past four years, Rainbow Health Ontario has offered full-day clinical modules on trans health care and has trained over 800 professionals across Ontario. Weekly mentorship calls are offered for providers to share cases and gain confidence. There are now a number of trans health care hubs where teams of primary care and community professionals are working together to provide sensitive and comprehensive services to trans clients (www.rainbowhealthontario.ca/trans-health-connection).

4. **LGBT data gaps need to be addressed with shorter-term and longer-term strategies. LGBT data needs to be collected in national surveys and by providers; and be included in a consistent, province-wide approach to planning based on population needs.**

Unfortunately, there is currently little population-level data on LGBT individuals and communities. The Canadian Census collects data only on same-sex couples, which says little about the size of the population. While the Canadian Community Health Survey does ask about sexual orientation, it does not ask about gender identity. Canada, in comparison with other countries, is falling behind with respect to data collection on sexual and gender minorities and also in national strategies to promote LGBT research and standards of service in health care and other governmental services (US HHS 2013, UK Government, 2011). With a new national government in office, the MOHLTC has the opportunity to work with their federal counterparts to address this national data collection gap.

In the shorter term, the data gap must be addressed through service providers' socio-demographic questions at the time of client intake. Toronto Central LHIN, in partnership with hospitals and community health centres, has developed a series of socio-demographic questions that are a good practice that should be scaled up across the province (see Appendix A).[2] Currently, these questions are only being mandated within Toronto Central LHIN health service providers (HSPs). AOHC requested that the LHINs make these socio-demographic questions a requirement for all LHIN-funded HSPs in the province but was unsuccessful. CHCs across the province are voluntarily collecting these data. While a consistent, provincial approach is needed to understand and plan based on population needs, the LGBT data gap must be filled from the 'bottom up' until population-level data becomes available. The provincial methodology developed must take this into consideration.

Finally, Local Health Integration Networks (LHINs) need to conduct assessments of the health and social service needs of LGBT people and the adequacy of generic services in their regions or sub-regions. According to Rainbow Health Ontario, only one LHIN (Waterloo/Wellington) has actually conducted a needs assessment focused on its local LGBT population (2012), while the Champlain LHIN has recently held a consultation to determine how it can better capture data (2015). This is a process that RHO and other community organizations can assist with in regard to outreach, questions and analysis.

Conclusion

Once again, thank you for providing this momentous opportunity to help transform the system to improve health equity and reduce health disparities. RHO and AOHC look forward to working with you towards continuing to create a province that enables LGBT health and wellbeing.

[2] For details, visit http://torontohealthequity.ca/

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Appendix A

We Ask Because We Care

We are collecting social information from clients to find out who we serve and what unique needs our clients have. We will also use this information to understand client experiences and outcomes.

Do I have to answer all the questions?

No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

Who will see this information?

This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other clients and no one will be able to identify any of the clients.

1. What language would you feel most comfortable speaking in with your health care provider? Check **ONE** only

☐ 1. Amharic	☐ 9. English	☐ 17. Korean	☐ 25. Somali	☐ 33. Urdu
☐ 2. Arabic	☐ 10. Farsi	☐ 18. Nepali	☐ 26. Spanish	☐ 34. Vietnamese
☐ 3. ASL	☐ 11. French	☐ 19. Polish	☐ 27. Tagalog	☐ 35. Other (please specify): _____
☐ 4. Bengali	☐ 12. Greek	☐ 20. Portuguese	☐ 28. Tamil	
☐ 5. Chinese (Cantonese)	☐ 13. Hindi	☐ 21. Punjabi	☐ 29. Tigrinya	
☐ 6. Chinese (Mandarin)	☐ 14. Hungarian	☐ 22. Russian	☐ 30. Turkish	☐ 98. Do not know
☐ 7. Czech	☐ 15. Italian	☐ 23. Serbian	☐ 31. Twi	☐ 99. Prefer not to answer
☐ 8. Dari	☐ 16. Karen	☐ 24. Slovak	☐ 32. Ukrainian	

2. Were you born in Canada? ☐ 1. Yes ☐ 2. No ☐ 98. Do not know ☐ 99. Prefer not to answer

If **NO**, what year did you arrive in Canada? _____

3. Which of the following best describes your racial or ethnic group? Check **ONE** only

☐ 1. Asian - East (e.g. Chinese, Japanese, Korean)	☐ 11. Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ 2. Asian - South (e.g. Indian, Pakistani, Sri Lankan)	☐ 12. Métis
☐ 3. Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	☐ 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ 4. Black - African (e.g. Ghanaian, Kenyan, Somali)	☐ 14. White - European (e.g. English, Italian, Portuguese, Russian)
☐ 5. Black - Caribbean (e.g. Barbadian, Jamaican)	☐ 15. White - North American (e.g. Canadian, American)
☐ 6. Black - North American (e.g. Canadian, American)	☐ 16. Mixed heritage (e.g. Black - African & White - North American) Please specify: _____
☐ 7. First Nations	
☐ 8. Indian - Caribbean (e.g. Guyanese with origins in India)	☐ 17. Other(s): Please specify: _____
☐ 9. Indigenous/Aboriginal - *not included elsewhere*	☐ 98. Do not know
☐ 10. Inuit	☐ 99. Prefer not to answer

4. Do you have any of the following? Check **ALL** that apply	
☐ 1. Chronic Illness	☐ 9.None
☐ 2. Developmental Disability	☐ 98. Do not know
☐ 3. Drug or Alcohol Dependence	☐ 99. Prefer not to answer
☐ 4. Learning Disability	
☐ 5. Mental Illness	
☐ 6. Physical Disability	
☐ 7. Sensory Disability (i.e. hearing or vision loss)	
☐ 8. Other (Please specify):_____	

5. What is your gender? Check **ONE** only	
☐ 1. Female	☐ 7. Other (Please specify):_____
☐ 2. Intersex	☐ 98. Do not know
☐ 3. Male	☐ 99. Prefer not to answer
☐ 4. Trans - Female to Male	
☐ 5. Trans - Male to Female	
☐ 6. Two-Spirit (a term used by Aboriginal people)	

6. What is your sexual orientation? Check **ONE** only	
☐ 1. Bisexual	☐ 7. Other (Please specify):_____
☐ 2. Gay	☐ 98. Do not know
☐ 3. Heterosexual	☐ 99. Prefer not to answer
☐ 4. Lesbian	
☐ 5. Queer (a term used by people who do not follow common sexual orientations)	
☐ 6. Two-Spirit (a term used by Aboriginal people)	

7. What was your total family income before taxes last year? Check **ONE** only	
☐ 1. $0 - $14,999	☐ 6. $35,000 – $39,999
☐ 2. $15,000 – $19,999	☐ 7. $40,000 – $59,999
☐ 3. $20,000 – $24,999	☐ 8. $60,000 or more
☐ 4. $25,000 – $29,999	☐ 98. Do not know
☐ 5. $30,000 – $34,999	☐ 99. Prefer not to answer

8. How many people does this income support?

_____person(s) ☐ 98. Do not know ☐ 99. Prefer not to answer