Systems and Structures:
Catalyzing effective healthcare for 2SLGBTQI+ populations

Devon MacFarlane
February 2026

draft – for discussion

I think that when we’re looking at services that are accessible to the LGBT population, we’re also looking at services that are accessible - accessible to people with disabilities, who are queer, who are First Nations, who have children, who are addicted to substances…

Because those are sometimes all one person.

“Gina,” Counsellor in Vancouver’s Downtown Eastside

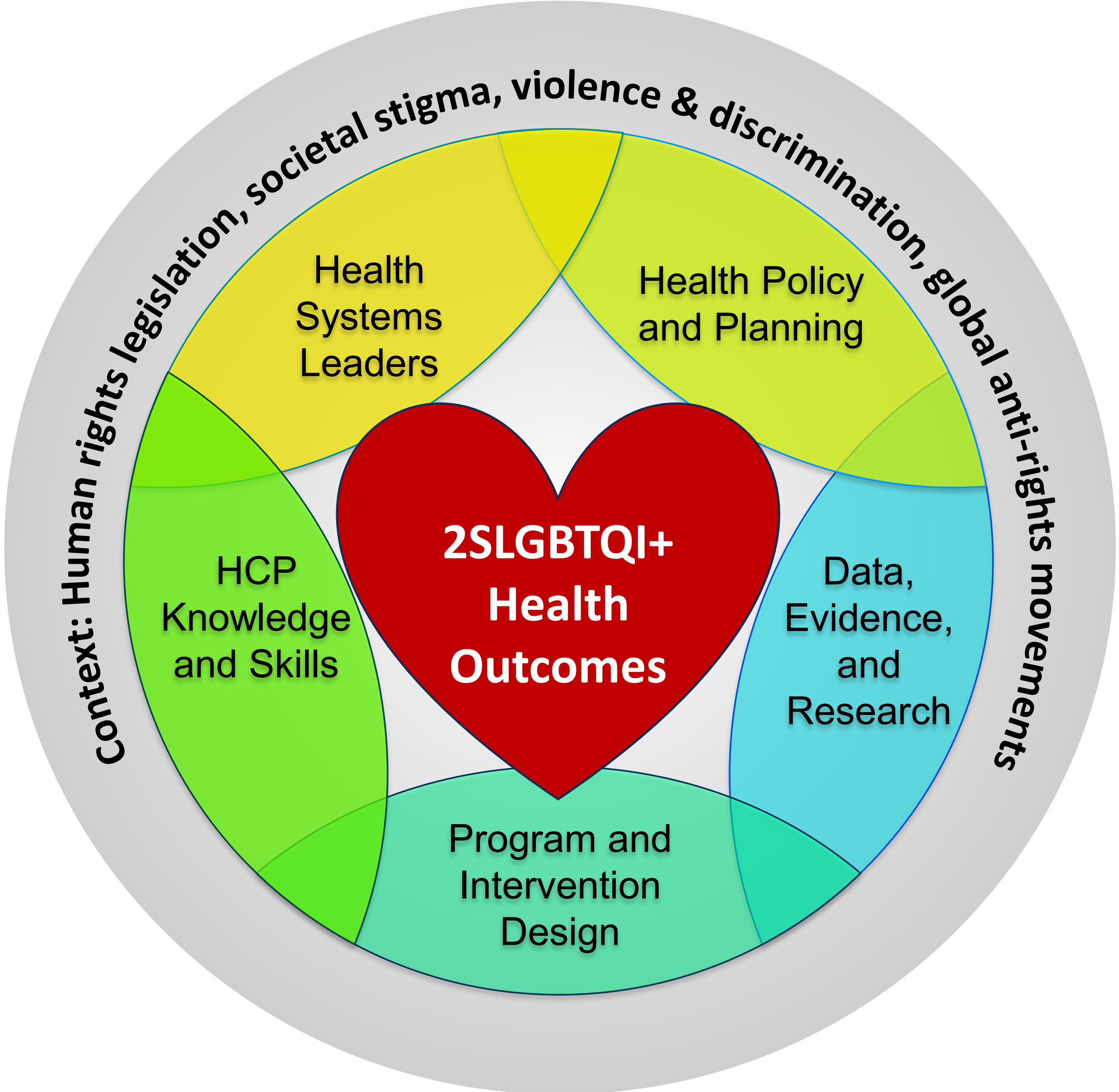
MacFarlane, D. (2003) LGBT communities and substance use: What health has to do with it! A report on community consultations. LGBT Health Association of B.C.

Question Zero

How do we create the conditions to improve access to health care, experiences in health care, and health outcomes for the full diversity of 2SLGBTQI+ people in Canada?

- What approaches in health systems and health sector organizations would help to advance this?
- What means for supporting the healthcare workforce could have an impact?
- What approaches to engaging governments would help to support this?
- What evidence could make a difference?

Systems Approach



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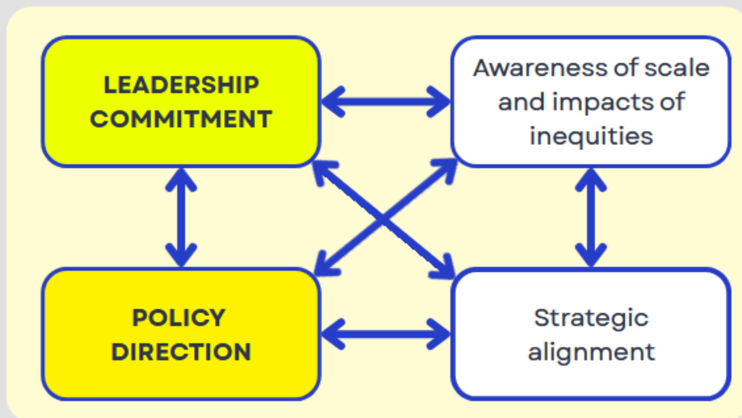
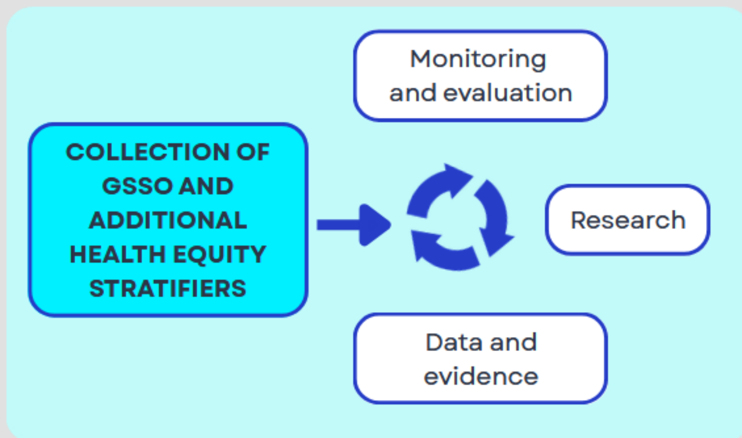
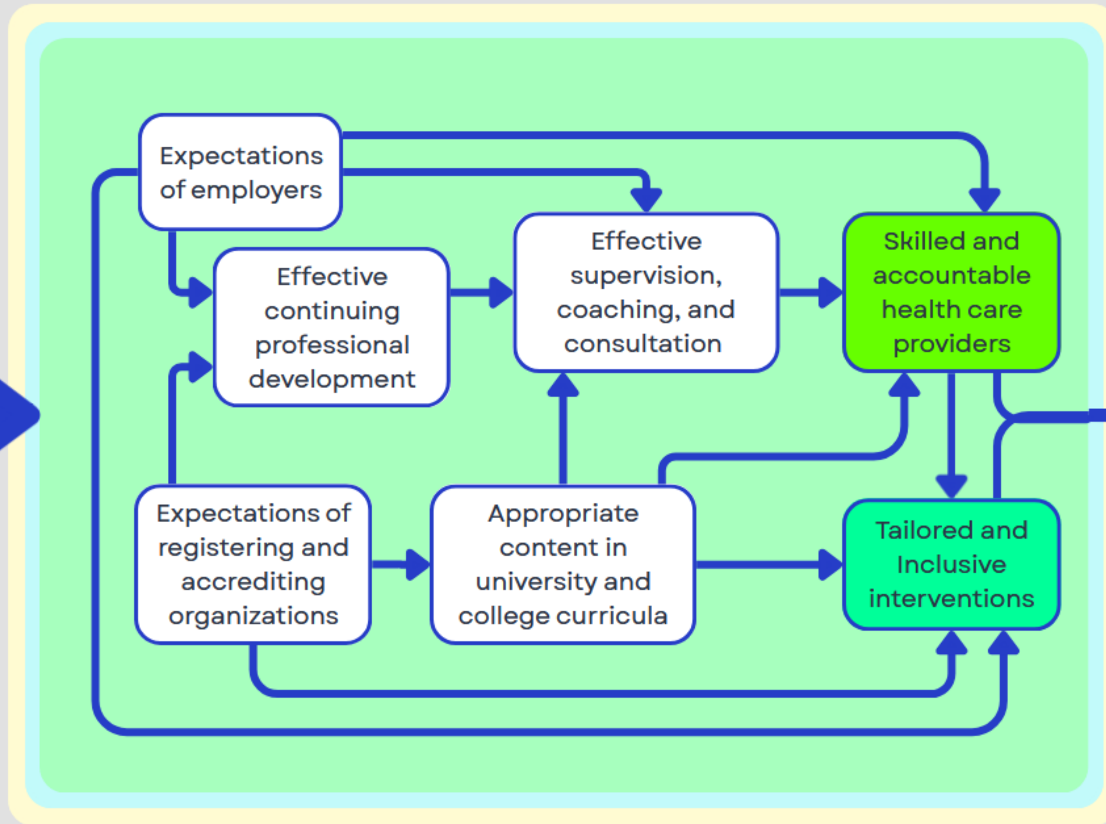
Pathways for advancing health care for 2SLGBTQI+ populations

HUMAN RIGHTS: LEGISLATION & COMPLAINTS







CULTURALLY RELEVANT and SAFE CARE

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Stories

Institutional heterosexism

Almost every time Aiysha* went to the emergency department or needed to find a new primary care provider, one of the questions she was asked early on was “are you sexually active?” When she answered yes, that question was followed immediately by “what form of birth control are you using.”

As a lesbian, Aiysha was very conscious that the questions were based on an assumption that she was straight. Those assumptions had intensified since she started wearing a hijab.

The questions, alongside the lack of any visible indication that these healthcare settings were welcoming of 2SLGBTQI+ people, had her feel anxious about how to tell these health care providers that birth control wasn’t relevant for her. She was concerned about how they would react, and how that would affect the care she would receive.

Eventually, Aiysha finally found a primary care team where everything felt inclusive. Aiysha appreciated seeing content about 2SLGBTQI+ people and racialized people on the website. When she went in for her first appointment, the forms for registering as a new patient were inclusive. And, she appreciated how her new primary care provider asked questions about her health, her family and social supports, and her sexual history – she felt like her primary care provider was understanding and empathetic, including about her past poor experiences. Through these positive experiences, Aiysha felt her trust starting to return in health care, and realized she wouldn’t have to avoid care any longer.

*Fictionalized scenario

Grief and depression

Nadine*, who is a 60s Scoop survivor, has been grieving her wife, who died by suicide almost a year ago. She has been very isolated, and her friends are worried about her. Grief has compounded the depression and anxiety she has experienced much of her life.

Nadine tried going to a bereavement support group. In the group, when Nadine said that her wife had died, some people reacted in a way where she then felt she couldn't talk about her complicated grief, including in relation to her adoptive father's death five years ago. Her adoptive parents had rejected her when she came out as lesbian to them when she was in her early 20s. She and her adoptive parents were not in contact for many years, until shortly before her adoptive father's death. Nadine's parents never acknowledged her wife's existence.

Nadine's grief and depression has also been affecting her ability to manage her diabetes, and her family doctor's office doesn't offer more intensive support. Although a local Indigenous health organization offers wellbeing programming, including for diabetes care, Nadine was reluctant to go. Given her loss of culture and that she is Two Spirit, she was anxious about whether or not she would be welcomed.

At Nadine's request, the care coordinator at her doctor's office called up the Indigenous health organization to gather more information. After Nadine learned that the organization offered some programming specifically for Two Spirit people, and that it had worked with many 60s Scoop survivors, she gave it a try and found it very helpful.

*Fictionalized scenario

Needing to hide

Ming and Paolo* had been together for 32 years when Ming needed to go into a long-term care home. When they were considering which ones go on a waitlist for, none of the long-term care homes in their community showed any awareness that 2SLGBTQI+ seniors existed. As they were very concerned about homophobia from both other residents and staff, they did all that they could to hide their relationship during the application process and after Ming moved in.

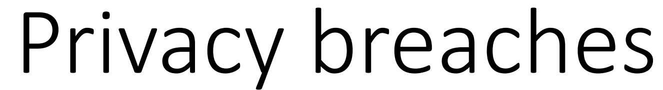
While the times and cultures they grew up in had them prefer to be fairly private about their relationship, having to conceal their relationship at home was new, and very difficult. The only times Ming and Paolo felt comfortable to hug or hold hands was if a friend was visiting and could guard the door to Ming's room, or if they went into the bathroom and locked the door. They also felt like they had to talk in coded language because of the risk of being overheard.

Over time, the long term care facility began working on 2SLGBTQI+ inclusion.

Eventually, Ming felt safe enough to open up to some staff. After the care home started offering some 2SLGBTQI+ specific programming, Ming went to some events and then opened up to some other residents who also attended the programming.

Not having to hide as much, and having institutional support, made a world of difference to both Ming's and Paulo's relationship, stress levels and quality of life.

*Fictionalized scenario



Privacy breaches

Maria* went to the hospital for some tests. A nurse came out to the waiting room, where Maria was sitting, and called out "Mr. Garcia." When Maria got up in response to her last name being called out, everybody looked.

By calling out "Mr.," the nurse disclosed Maria's personal information – that she was trans – to all the people in the waiting room. Unfortunately, something along these lines often happened when Maria went for health care.

Maria had tried self-advocating, including calling up supervisors to bring up concerns about being misgendered and "outed" in the waiting room. In some conversations, she heard that some organizations' policies were to call out the gender on the health card. In other cases, the name that came up in electronic records was her former legal name, and the team did not know how to – or was unable to – eradicate her previous first name from the records.

Another approach Maria tried was to inform the person at the front desk of what name she went by, and that she wouldn't be coming forward if the wrong name, or if "Mr." was called out; this sometimes worked.

The constant need for advocacy to avoid privacy breaches – along with other problems, such as having to educate her health care providers – had Maria feeling exhausted and on edge about the idea of even engaging with the health care system, resulting in her avoiding care as much as possible.

*Fictionalized scenario

The data

How many people are we talking about?

In general

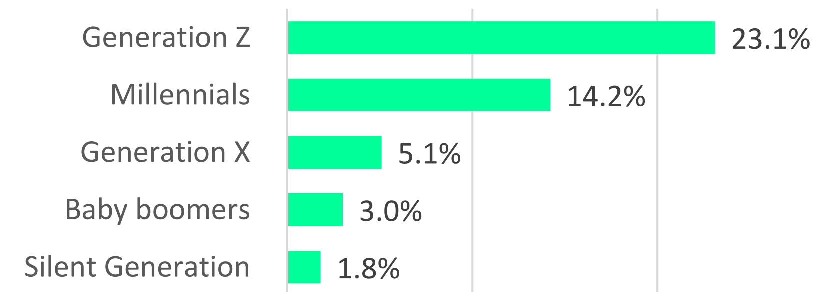
- Population size often underestimated.
- Younger people disclosing more often; more girls / women disclosing than boys / men.

Statistics Canada

- 4.4% of the Canadian population age 15+ identifies as 2SLGBTQ+ (2019-2021)
  - Likely a significant underestimate due to reluctance to disclose to government
- In 2019, 21% of Canadian adolescents (age 15-17) reported attraction "not exclusive to the opposite gender"

Gallup Poll (US)

- In 2024, 9.3% of total US population age 18+ identified as LGBTQ+
  - However, 23.1% of Generation Z is LGBTQ+
- Over 56% of the LGBTQ+ population is bisexual.
- Largest single group is young bisexual women.
- Older generations more likely to identify as lesbian or gay



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Wang, C. et al. (2023). Gender identity and sexual attraction among Canadian youth: findings from the 2019 Canadian Health Survey on Children and Youth. *Health Promotion and Chronic Disease Prevention in Canada 43*(6)

Gallup. (2025). LGBTQ+ Identification in the US rises to 9.3%.

Trans Pulse Canada. (2022). QuickStat #5: How trans and non-binary participants would be counted in a Statistics Canada Survey.

What are the inequities in health outcomes?

Significantly higher burden of mental and physical ill-health, functional health difficulties, disabilities.

- 50% more highly preventable deaths than for heterosexuals (deaths from heart disease, accidents, HIV, suicide).

Health is often poorest for bisexual women, lesbians, and trans people.

- Higher rates of a range of chronic conditions, including asthma, arthritis, COPD, diabetes, heart disease, with some being much higher.
    - E.g., rates of heart disease are 3x higher for bisexual women than heterosexual women

Overall, very high rates of mental health concerns.

- Mood or anxiety disorders: 61% of trans people. Amongst cisgender women: 37.1% of bisexual women, 27.4% of lesbians vs 16.1% heterosexual women. Amongst cisgender men: 21.% bisexual men, 17.3% gay men, vs 8.9% heterosexual men.
- Higher rates of lifetime suicidal ideation (64.3% trans, 40% LGB, vs 16.6% heterosexual)
- Higher rates of lifetime suicide attempts (36.5% trans, 16.6% bisexual, 8.6% lesbian and gay, vs 2.8 heterosexual)

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Liu, L. et al.(2023) Suicidality and protective factors among sexual and gender minority youth and adults in Canada BMC Public Health 23(1)
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Rabinowitz, T (2024) A profile of 2SLGBTQI+ people with disabilities. Statistics Canada
Rauh, K. (2023) Functional health difficulties among lesbian, gay, and bisexual people in Canada Statistics Canada.
Rauh, K et al. (2025) Socioeconomic outcomes of transgender and non-binary people in CanadaStatistics Canada

What are the health access issues?

- 2SLGBTQI+ people have lower rates of attachment to primary care providers (84.3% for heterosexuals vs 82.7% for LGB people; 81% for trans adults and 78% for trans youth) and higher rates of unmet health care needs
  - Rates of unmet health care needs approximately 11x higher for trans people and 3x higher for LGB people than the general population
- While about ½ of LGB people have sought support for mental health or substance use in the past year (vs about ¼ of heterosexuals), almost 6 in 10 LGB populations have past-year unmet mental health needs (vs. 4 in 10 of heterosexuals)
- While health care provider attitudes towards 2SLGBTQI+ populations are improving, discrimination (individual and structural level) continues.
  - Discrimination and poor experiences of care create fear, barriers to care and avoidance of care, and high rates of distrust in health care system
- Fears and past poor experiences contribute to very high rates of non-disclosure of sexual orientation or gender identity to health care providers (non-disclosure by 30%-50% of 2SLGBTQI+ people)
- Access to respectful and effective care is more challenging in rural communities and on reserves.
- Structural discrimination can result in barriers to diagnoses

Comeau, D., et al. (2023). Review of current 2SLGBTQIA+ inequities in the Canadian health care system. *Frontiers in Public Health*

Hickey, P.M., et al. (2024). Access to healthcare and unmet needs in the Canadian lesbian-gay-bisexual population. *Journal of Homosexuality 71*(14)

Pan-Canadian health inequalities data tool, 2022 edition. A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada, and the Canadian Institute of Health Information.

Mulholland, A.D., et al. (2022) Experiences of trans patients in primary care settings: Findings from the OutLook study. *Sexual Health 19* 132-140.

Taylor, A.B., et al. (2020). Being Safe, Being Me 2019: Results of the Canadian Trans and Non-binary Youth Health Survey. Vancouver, Canada: Stigma and Resilience Among Vulnerable Youth Centre, University of British Columbia.

Trans Pulse Canada. (2020). QuickStat #2: How does health care access for trans and non-binary people in Canada compare to the general population?

What are the problems in patient experiences?

- Problems include individual and systemic discrimination, heterosexist assumptions, privacy breaches, coming out / disclosure of identity, lack of health care provider knowledge, lack of positive space signalling and welcoming environments (e.g. gender-neutral washrooms, inclusive forms).
  - Individual discrimination includes refusal to provide care for 2SLGBTQI+ populations.

- To date, Canadian patient experience and patient outcome surveys to date have not included questions that allow 2SLGBTQI+ respondents to effectively disclose (i.e., gender, sex, and sexual orientation (GSSO))
  - Problems are thus rendered invisible.

- Although newer surveys (e.g. Statistics Canada's new Survey on Health Care Access and Experiences – Primary and Specialist Care) do ask questions regarding GSSO, results are not yet available.

Campbell, J., et al. (2023). Lesbian, gay, bisexual, or queer patient experiences in Canadian primary care and emergency departments: a literature review. *Culture, Health & Sexuality, 25*(12)
Canadian Institute for Health Information. (2025). Canadian Patient Experiences Survey – Inpatient Care Procedure Manual.
Comeau, D., et al.. (2023). Review of current 2SLGBTQIA+ inequities in the Canadian health care system. *Frontiers in Public Health*
Canadian Institute for Health Information. Does CIHI have pan-Canadian standards for gender, sex and sexual orientation?. Accessed July 21, 2025.
Government of Ontario. (nd). The Health Care Experience Survey.
Statistics Canada (n.d.) Survey on Health Care Access and Experiences – Primary and Specialist Care

What are the gaps in healthcare service delivery?

Programs and services are seldom designed to be inclusive of 2SLGBTQI+ communities
- Fewer are tailored to meet the specific health care needs, contexts, and risk factors

Screening:
2SLGBTQI+ people are less likely to receive or be up to date on screening for diseases, chronic conditions, and mental health and substance use concerns.

Inclusive and / or tailored treatment and interventions:
Areas of need span the life course:
- Fertility care
- Child and youth health, including prevention and health promotion
- Transition-related care
- Chronic disease prevention and management, including for mental health and substance use
- Suicide prevention, intervention, and postvention
- Cancer prevention, treatment and support
- Home care, long term care, palliative care, and bereavement

Ferlatte, O. et al. (2020). It is time to mobilize suicide prevention for sexual and gender minorities. Canadian Journal of Public Health. 111.
Ferlatte, O. et al. (2021). 2SLGBTQI+ Suicide Prevention Research in Canada: Evidence, Gaps and Priorities: PHAC Suicide and its Prevention Final Report. Egale Canada
Kiran, T. et al. (2019). Cancer screening rates among transgender adults: Cross-sectional analysis of primary care data. Canadian Family Physician 65(1)
Mental Health Commission of Canada. (2023). Suicide postvention resources for Canadian Communities.
Queering Cancer. (2024). Queering Cancer: Pride in inclusive cancer care.
Registered Nurses' Association of Ontario (RNAO). (2021). Promoting 2SLGBTQI+ Health Equity.
Robinson, L. et al. (2023). Applied patient-level palliative care interventions designed to meet the needs of sexual and gender minorities: A scoping review and qualitative content analysis of how to support sexual and gender minorities at end of life. Palliative Medicine 38(1).

How does stigma contribute to this?

Stigma is a fundamental cause of health inequities for 2SLGBTQI+ populations

- Functions at structural and individual levels
- Includes discrimination, rejection, physical and sexual violence, internalized shame, etc.
- Can be compounded by other forms of disadvantage, discrimination and marginalization (e.g., impacts of colonization, racism, ableism, poverty, homelessness)

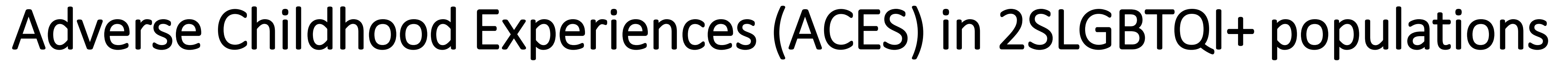
"Minority stress" is chronic stress arising from experiencing and anticipating stigma

- Negatively impacts physical and mental health.

"Fundamental cause theory" explains health disparities associated with poorer access to material and social resources (e.g., income, employment, family support)

- In Canada, 2SLGBTQI+ people have higher levels of education AND lower income levels than non-2SLGBTQI+ people.

Earnshaw, V.A et al. (2024). Chapter 2: LGBTQ Stigma. In Global LGBTQ Health: Research, Policy, Practice, and Pathways
Flentje, A. et al. (2025). Minority stress in relation to biological outcomes among sexual and gender minority people: A systematic review and update. Journal of behavioural medicine 48(1)
Hatzenbuehler, M.L, et al. (2013) Stigma as a fundamental cause of population health inequalities. American Journal of Public Health 103(5)
Mongelli, F. et al. (2019) Minority stress and mental health among LGBT populations: An update on the evidence. Minerva Psichiatrica 60(1)
Statistics Canada. (2024). Socioeconomic profile of the 2SLGBTQ+ population age 15 years and older, 2019-2021



Adverse Childhood Experiences (ACES) in 2SLGBTQI+ populations

An analysis Statistics Canada 2019 General Social Survey found that in Ontario:

- LGB people reported almost 2x the rates of any ACEs (66.7% LGB vs 34.2%)

  Greatest difference are for:
  - Emotional abuse (51.8% for LGB vs 24.5% for heterosexual)
  - Exposure to household violence (34.7% vs 17.0%)

- LGB people experienced highest rates of any socio-demographic category examined in this study
  - Categories included sex, age, sexual orientation, racialization and place of birth, disability, relationships, living arrangements, education and income

Researchers have recommended expansions to ACE frameworks

- For a 2SLGBTQI+ specific ACE in addition to standard measured
- 2SLGBTQI+ qualifiers for existing measures
- Expansion to reflect unique ACE contexts for 2SLGBTQI+ young people

Baker, S.J., et al. (2025). Wellesley Institute. Inequities in adverse childhood experiences in Ontario: A descriptive analysis of the Canadian Longitudinal Study on Aging and the General Social Survey
Jones, M.S., et al. (2025). Measuring the prevalence and impact of adverse childhood experiences in the lives of LGBTQ individuals: A much-needed expansion Child Abuse & Neglect 168(1)

Violence, Harassment and Health

Violence and Harassment

- 2SLGBTQI+ Canadians are more likely to have experienced physical or sexual assault since age 15 than heterosexual Canadians (59% LGB vs 37% heterosexual)
    - Violence was more likely to result in injuries than for heterosexual Canadians

- Past 5 years - violence or Harassment experienced by trans and non-binary people in Canada
    - 68% verbal harassment; 42% sexual harassment; 37% physical intimidation or threats; 26% sexual assault; 16% physical assault

- 2SLGBTQI+ Canadians more likely to experience inappropriate behaviours in the last 12 months,
    - In public (57% for LGB vs 22% for heterosexual)
    - Online (37% LGB vs 15% heterosexual)
    - At work (44% LGB vs 22% heterosexual)
    - Higher rates of using substances to cope with emotional abuse and physical violence (24% LGB vs 10% heterosexual)

Bullying in schools

- Amongst youth age 15-17, 77% of 2SLGBTQ+ youth experienced past- year bullying vs 69% of cisgender youth.
    - 2SLGBTQI+ youth reported more frequent bullying than cisgender youth, were more likely to experience more forms of bullying, and reported the highest levels of negative mental health outcomes

Jaffray, B. (2020). *Experiences of violent victimization and unwanted sexual behaviours among gay, lesbian, bisexual and other sexual minority people, and the transgender population, in Canada, 2018*. Statistics Canada.

Prokopenko , E. & Hango, D. (2022). Bullying victimization among sexually and gender diverse youth in Canada. Statistics Canada

Trans Pulse Canada (2020) Health and Health Care Access for Trans & Non-binary People in Canada

What are the systems level challenges in health care?

- Health systems are generally not yet addressing health inequities for 2SLGBTQI+ population
- Data on gender, sex, and sexual orientation (GSSO) are seldom collected in electronic health records or administrative data
  - CIHI has developed pan-Canadian data standards for GSSO, creating a foundation for change.
- Limited emphasis in health care provider, management, and leadership training curricula on 2SLGBTQI+ health; gaps in subjects taught.
  - Contributes to lack of awareness of inequities, lack of skills in addressing issues facing 2SLGBTQI+ health.

Every system
is perfectly designed
to get the results
that it gets.
- Arthur Jones and Paul Bataden

Campbell, J., et al. (2023). Lesbian, gay, bisexual, or queer patient experiences in Canadian primary care and emergency departments: a literature review. *Culture, Health & Sexuality, 25*(12)
Comeau, D., et al. (2023). Review of current 2SLGBTQIA+ inequities in the Canadian health care system. *Frontiers in Public Health*
Conway, E., et al. (2015). Like Magic? ("Every system is perfectly designed...")
Canadian Institute for Health Information. Does CIHI have pan-Canadian standards for gender, sex and sexual orientation?. Accessed July 21, 2025.

What are the costs of inequities?

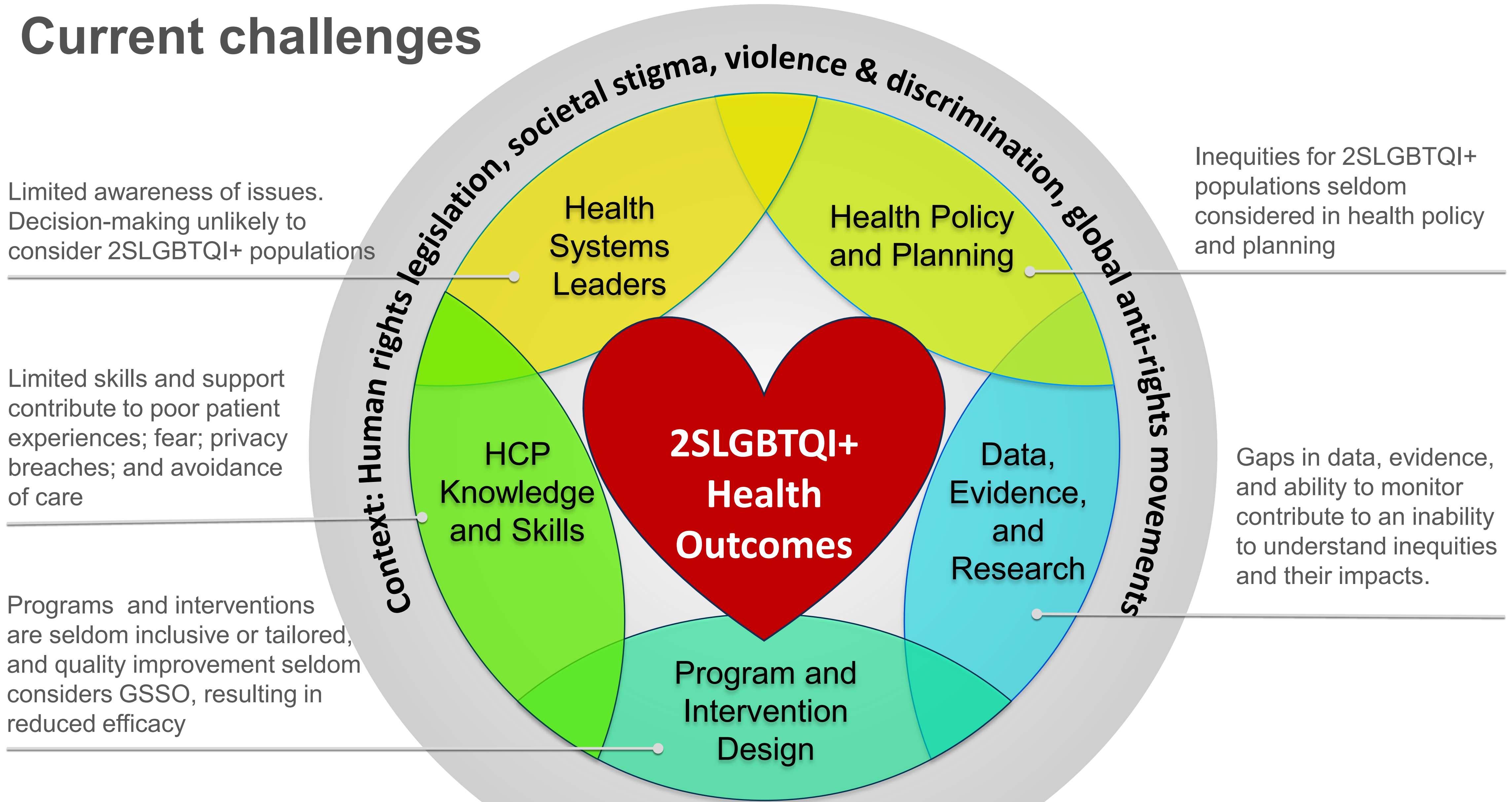
Health inequities are expensive, though little health economics research about 2SLGBTQI+ populations has been completed. Productivity losses are also significant.

- For cardiometabolic conditions (e.g. diabetes, heart disease) hospitalization lengths of stay are approximately 2.5 times longer for LGB people than heterosexuals (13.6 days v. 5.1 days).
  - Costs of care about 2.5x higher for LGB people: $26,702 vs. $10,137 for heterosexuals.
- In Ontario, annual health systems savings that could be accrued through reducing rates of breast, colorectal, and cervical cancer for lesbians and bi women to those of heterosexual women is between $43.7M-$190.9M
  - Associated annual productivity losses due were an estimated 70 disability-adjusted life years, or $3.8 to $11.6M losses to Ontario's GDP
- In Ontario, 2SLGBTQI+ populations lost an estimated 1,611 disability-adjusted life years annually that were in excess of general population rates for mental health concerns (depressive disorders, mood and anxiety disorders, suicidality)
  - Associated annual productivity losses were $88.8M-$266.3M in GDP

Gupta, N., et al. (2020). Disparities in the hospital cost of cardiometabolic diseases among lesbian, gay, and bisexual Canadians: A population-based cohort study using linked data. *Canadian Journal of Public Health = Revue Canadienne de Santé Publique*, *111*(3), 417–425.C
Rainbow Health Ontario. (2019). LGBTQ2 Health In Canada: Study Brief for the Standing Committee on Health

Challenges (and opportunities) are mutually-reinforcing

Current challenges



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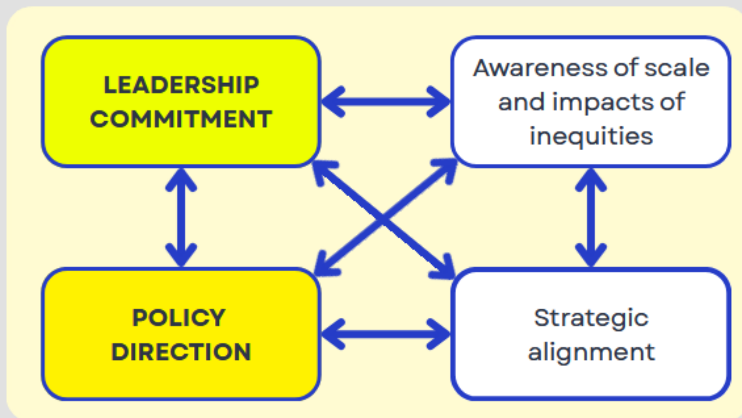
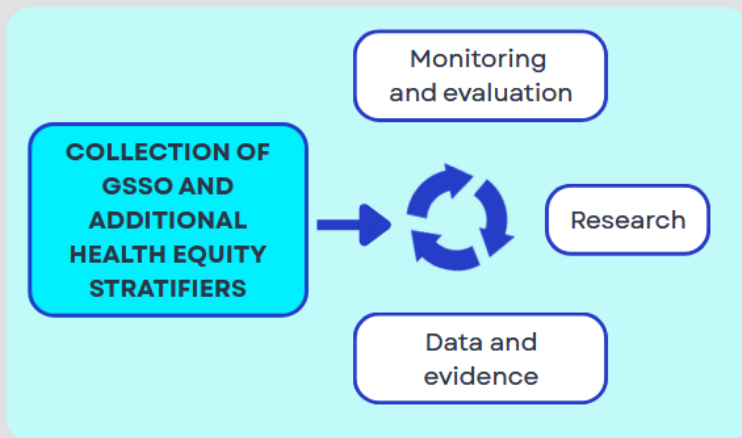
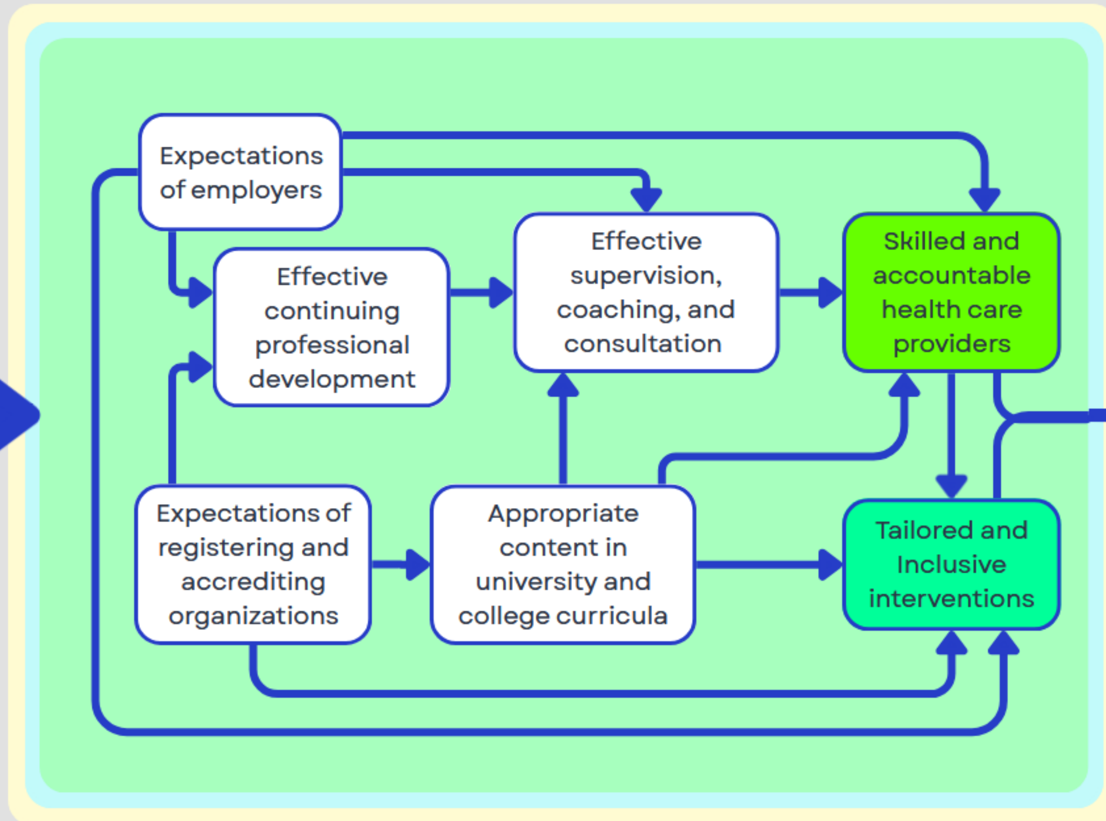
Pathways for advancing health care for 2SLGBTQI+ populations







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What might help to foster change?

Areas for Action: Overview

Health System Leaders	Health Policy Development and Implementation	Data, Evidence, and Research	Programs and Interventions	Health Care Providers' Knowledge and Skills
• Increase awareness and leadership • Address systemic discrimination • Ensure strategic positioning • Increase ability to engage in oversight • Enhance decision making • Ensure effective resource allocation	• Advance inclusion in policy • Make strategic investments	• Develop key tools, norms, and guardrails • Include in key data collection vehicles • Advance research • Support knowledge mobilization	• Integrate in Quality Improvement • Implement inclusive programs and interventions • Implement tailored programs and interventions • Disseminate effective interventions	• Develop clear expectations and competencies • Include in undergraduate and graduate programs • Advance key continuing professional development

Data, Evidence, and Research

Develop tools, norms, and guardrails

- Develop guidelines regarding how and when data should be collected
- Establish norms regarding analysis and reporting on GSSO data, including from an intersectional perspective – e.g. by sexual orientations and gender identities, by race / ethnicity, across the life course, etc.
- Develop guardrails, including data governance approaches, to reduce risk of data misuse

Include in key data collection vehicles

- Ensure inclusion of GSSO and other key information fields in data collection vehicles such as EMRs, patient experience and outcomes surveys, and health administrative data, including provincial health insurance registration and renewal
- Create initiatives to ensure effective collection of GSSO data in these vehicles

Advance research

- Advance research addressing 2SLGBTQI+ health in areas such as health economics, effective approaches to systems change and behavioural change regarding stigmatized populations, and program interventions
- Work with stakeholders from 2SLGBTQI+ communities as well as health systems and health policy leaders to develop research agendas

Support knowledge mobilization

- Foster awareness of new research amongst health policy and health systems actors in relation to 2SLGBTQI+ health.

Strengthening data availability

- Developing guidelines for the inclusion of gender, sex, and sexual orientation (GSSO), and other pertinent fields, in:
  - Provincial and territorial health insurance registration and renewal
  - Patient-reported experience and outcomes surveys (e.g., PREMS and PROMS)
  - Coroner’s and medical examiners’ reports
  - Initiatives supporting the wellbeing of the healthcare workforce

Stewart, K & Dyck, D.R. (n.d.) LGBTQ Youth Suicide: Coroner/Medical Examiner Investigative Protocol

Fostering systems change

- How can knowledge be effectively mobilized about means to advance systems change that better serves 2SLGBTQI+ populations and other marginalized communities?

- What contributes – or would likely contribute - to organizations meaningfully address 2SLGBTQI+ health, and how can these approaches be spread?

Making the case: Health economics & macro-economics

- Differences in length of stay, costs of stay (in hospitals)
  - Consider current and emerging health systems priorities, e.g.,
    - Ambulatory care sensitive conditions (conditions that should be manageable through primary care)
    - Concerns relating to mental health and substance use
    - Alternative Level of Care days
- Economic modeling
  - Cost savings and return on investments expected to arise through reducing inequitable health outcomes
  - Lost productivity (measures such as disability-adjusted life years (DALYs); impact on GDP)

Saewyc E., Poon C., Kovaleva K., Tourand J., & Smith A. (2016). School-based interventions to reduce health disparities among LGBTQ youth: Considering the evidence. Vancouver: McCreary Centre Society & Stigma and Resilience Among Vulnerable Youth Centre

Making the case: Potential demand

- Identify health issues and contexts where interventions tailored for 2SLGBTQI+ communities would be clinically warranted

- Model potential demand for a program or intervention
  - Consider not only population size but higher rates of specific health concerns, and variations in prevalence across sexual orientations, gender identities, and additional factors (age range, etc).
    - E.g., of the people who are likely to need, or seek, support for a form of health care (e.g. chronic disease management, mental health, substance use) what proportion might be from 2SLGBTQI+ communities?
  - Explore to what degree existing programs are likely to meet the needs of 2SLGBTQI+ populations

Supporting Effective Service Provision

- Engage in intervention research
  - Develop targeted interventions, evaluate effectiveness to meet needs of 2SLGBTQI+ populations
    - Needed across a range of health concerns and service delivery setting, spanning prevention through treatment

  - Effective means to support health care providers in developing and applying skills needed to provide good care for 2SLGBTQI+ populations

Identifying improvement opportunities

- Examine patient-reported experience and outcomes measures (PREMs and PROMs), disaggregating by GSSO and other equity stratifiers
- Explore differences in pathways through care, severity of disease at diagnosis, effectiveness of care, outcome of care for 2SLGBTQI+ populations
- Apply strengths-based approaches, e.g.,
    - Positive experiences of care
    - Factors that support 2SLGBTQI+ older adults aging well at home
    - Social and community-level factors that contribute to better mental health outcomes
    - Health systems supports that could help prevent 2SLGBTQI+ youth homelessness

Appendix: Data Details

Chronic Diseases and Social Determinants of Health

Chronic Disease Prevalence

Arthritis

Population: Adults age 18+

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
Age-Standardized Rate	17.7%	20.2%	19.4%	23.8%	25.1%	36.9%
Rate difference	0	+1.1%	+1.7%	0	+1.3%	+13.1%
Rate ratio	1	1.14 times higher	1.10 times higher	1	1.06 times higher	1.55 times higher

Asthma

Population: Adults age 18+

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
Age-Standardized Rate	6.7%	9.7%	8.3%	9.2%	11.3%	14.9%
Rate difference	0	+3.0%	+1.7%	0	+2.1%	+5.7%
Rate ratio	1	1.46 times higher	1.25 times higher	1	1.23 times higher	1.62 times higher

Chronic Obstructive Pulmonary Disorder (COPD)

Population: Adults (35+) * Denotes use with caution. — Denotes data suppressed

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
Age-Standardized Rate	2.8%	3.2%*	—	3.2%	2.4%*	5.0%*
Rate difference	0	+0.3%*	—	0	- 0.8%*	+1.8%*
Rate ratio	1	1.11	—	1	0.74	1.55

Pan-Canadian Health Inequalities Data Tool, 2022 edition. (n.d.). A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada, and the Canadian Institute of Health Information

Chronic Disease Prevalence continued

Diabetes, excluding gestational (self-reported)

Population: Adults (18+) * Denotes use with caution.

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
Age-Standardized Rate	8.8%	7.3%	11.3%	5.9%	6.8%*	9.4%
Rate difference	0	-1.5%	+2.5%	0	+0.9%*	+3.5%
Rate ratio	1	0.83	1.28	1	1.16	1.60

Heart disease

Population Adults 18+

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
ASR	5.9%	5.7%*	4.9%	4.0%	4.7%*	12.3%
Rate difference	0	-0.2%	-1.0%	0	+0.8%	+8.33%
Rate ratio	1	0.95	0.83	1	1.19	3.11

Hypertension

Population: Adults 18+

Measure	Heterosexual men (ref)	Gay men	Bisexual men	Heterosexual women (ref)	Lesbians	Bisexual women
ASR	23.4%	20.9%	19.8%	20.3%	22.1%	21.9%
Rate difference	0	-2.5%	-3.6%	0	+1.8%	+1.6%
Rate ratio	1	0.89	0.85	1	1.09	1.08

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Income and Employment

- Median employment income is lowest for bisexual people.
  - Bisexual women - $38.5K bisexual men – $39.4K, lesbians - $48.6k, gay men - $51.4K, heterosexual women – $47.3K, heterosexual men - $61.4K
  - For racialized Canadian-born lesbian and gay people, average incomes are higher ($59.8K) than for their non-racialized counterparts ($49.9K), but lower for racialized bisexuals ($27.1K) vs non-racialized bisexuals ($39.1K)

- Trans people often under-employed, working part-time, and have employment instability
  - In Ontario, only 42% working permanent full-time; 49% had a personal income of under $30k.

Young adults not in employment, education, or training (NEET)

- 30.8% of trans women, 24.1% of trans men, and 22.4% of non binary people vs 16.8% cis men and 16.7% cis women
- Current data not available for LGB young adults

Rauh, K et al (2025) Socioeconomic outcomes of transgender and non-binary people in Canada Statistics Canada
Statistics Canada (2022) Labour and economic characteristics of lesbian, gay, and bisexual people in Canada
Statistics Canada (2023) Ethnocultural diversity among lesbian, gay and bisexual people in Canada: An overview of educational and economic outcomes
Trans Pulse Canada (2020) Health and Health Care Access for Trans & Non-binary People in Canada

Poverty rates

- 17.8% for nonbinary people, 11.1% trans women, 10.5% trans men vs 7.0% for cisgender men and 7% for cisgender women (age-adjusted)
- 41% of trans and nonbinary people in Ontario live in a low-income household

Core housing need

- Highest rates of need: 15.4% nonbinary people, 8.6% transgender women, 7.9% cisgender women, 7.6% transgender men, vs 6.4% cisgender men

Lifetime Homelessness (unsheltered and hidden) amongst people responsible for making housing decisions in their household

- Unsheltered: 7.6% lesbians and bisexual women; 2.6% gay and bisexual men vs 2.6% heterosexual men and 2.0% heterosexual women
- Hidden: 34.1% lesbians and bisexual women; 24.3% gay and bisexual men, vs 14.2% heterosexual women and 13.8% heterosexual men

Past 12 month food insecurity rates abre about Food insecurity rates are about 3x higher for bisexuals than their heterosexual counterparts

- 20.6% bisexual women, 19.1% bisexual men, 11.3% lesbians, 10.0% gay men, vs. 8.5% heterosexual women and 6.2% heterosexual men

Pan-Canadian Health Inequalities Data Tool, 2022 edition. (n.d.). A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada, and the Canadian Institute of Health Information
Rauh, K et al (2025) Socioeconomic outcomes of trans and non-binary people in Canada Statistics Canada
Trans Pulse Canada (2020) Health and Health Care Access for Trans & Non-binary People in Canada
Uppal, S. (2022) A portrait of Canadians who have been homeless. Statistics Canada

Disabilities

2SLGBTQI+ people with disabilities appear to be much younger on average (29 years) than non-2SLGBTQ+ counterparts (56 years)

- Among 2SLGBTQ people with disabilities, top 3 forms of disability were mental health (69.9%) pain (48.9%), and learning (36.8%)
- 15-24-year-old 2SLGBTQ+ people are more likely to have two or more types of disability, and have more severe disability, compared to their non-2SLGBTQ+ age peers

Age distribution for mental health related disabilities

- 84.1% among 2SLGBTQ+ people ages 15-24 (vs 61.1% of non-2SLGBTQ+ age-peers)
- 72.2% among 2SLGBTQ+ people ages 25-34 (vs 57.2% for non-2SLGBTQ+ age peers)
- 59.3% among 2SLGBTQ+ people ages 35-64 (comparator not provided for non-2SLGBTQ+ age peers)

Education and employment for people with disabilities

- 2SLGBTQ+ people are more likely to hold a bachelor’s degree or higher (32.5%) than their non-2SLGBTQ+ counterparts
- Employment rates were similar (about 2/3rds) for both 2SLGBTQ+ and non-2SLGBTQ+ people with disabilities
- Proportion of 2SLGBTQ+ people who were not in the labour force (23.8%) is lower than their non-2SLGBTQ+ counterparts (28.9%)

Key barriers to accessibility:

- Communication (61.0%), behaviours, misconceptions, or assumptions of others (57.6%), public spaces (55.5%) and activities related to using the internet (19.7%)

Rabinowitz, T. (2024) A profile of 2SLGBTQ+ persons with disabilities 2022. Statistics Canada

Belonging and Life Stress

By sexual orientation, age-standardized rates of having a somewhat or very strong sense of community belonging are:

- 57.1% bisexual men, 60.5% bisexual women, 63.6% gay men, 64.1% lesbians, vs 67.3% heterosexual men and 68.6% heterosexual women

Trans and non-binary Ontarians who avoided public spaces in the past 5 years (for fear of harassment or being outed)

- 64%: 3 or more types of spaces; 20%: 1 or 2 types of public spaces; 15%: no avoidance

Prevalence of high life stress

- 35.3% of bisexual women, 32.2% of lesbians, 31.5 % of gay men, 30.1% of bisexual men vs 26% of heterosexual women and 22.4% of heterosexual men

Health Infobase (2024) Inequalities in mental health, well-being, and wellness in Canada
Pan-Canadian Health Inequalities Data Tool, 2022 edition. (n.d.). A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada, and the Canadian Institute of Health Information
Trans Pulse Canada (2020) Health and Health Care Access for Trans & Non-binary People in Canada

Contact

LinkedIn: www.linkedin.com/in/devonmacfarlane

Blog: queeringhealth.substack.com

Email: devon.a.macfarlane@gmail.com